RESIDUAL FUNCTIONAL CAPACITY CERVICAL SPINE

Name:	
Claim #:	
Date of Injury:	

Please Print Name of Medical Evaluator:		
Medical Specialty:		
Has any medication necessary to relieve and/or control pain and/or the underlying condition(s) been denied?	Yes☐	No☐
If yes, has the claimant's functionality decreased as a result of the denied medication(s)?	Yes☐	No☐
Does claimant experience any side effects from the medication(s) that has not been denied?	Yes☐	No☐
Given the aforementioned and within a reasonable degree of medical probability please address the following questions:		
Can the claimant reasonably be expected to engage in sustained competitive work 8 hours a day 5 days a week considering the totality of his/her functional limitations?	Yes☐	No☐

How many hours can claimant reasonably expect to sustain competitive work if vocationally and medically compatible work is identified? Hour(s) each day:	<1	1	2	3	4	5	6	7	8

Are assistive device(s) medically required and/or prescribed?	Yes☐	No☐

Arm Brace(s)	Back Brace	Walker	Cane	Wheel Chair	Scooter	High back chair	Other:

The claimant's dominant extremity is:	Right ☐	Left ☐

NECK/HEAD/CERVICAL REGION (check capacity for each activity)

	(# of hours in an 8-hour day)									Duration/Tolerance minutes							
Physical Activity	**<1**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	<5 min	5-10	11-15	16-20	21-30	31-45	46-60	Other
Neck Flexion/ Extension																	
Neck Rotation																	

Can episodes of pain become *moderate*, *moderate to severe*, or *severe*? **[Circle one or more]** Other:	Yes☐	No☐
Is it reasonable to expect claimant's pain, as described above, to increase at times spontaneously, unpredictably and/or without provocation?	Yes☐	No☐
If yes, how often?		
If spontaneous spikes in pain occur as described above, how long can they be expected to last out of an 8-hour work day or its equivalent: 5% of the day; 10% of the day; 15% of the day, 20% of the day; Other_____% of the day		

CERVICOGENIC HEADACHES

Is there a medical probability that your patient's cervical condition will cause headaches?	Yes ☐	No ☐
On average please characterize your patient's headaches in terms of intensity/severity; minimum, slight, moderate, moderate/ severe, severe or other:		

Identify any other symptoms associated with your patient's headaches:

	Vertigo		Visual Disturbances
	Nausea/Vomiting		Mood Changes
	Malaise		Mental Confusion/Inability to Concentrate

What is the average frequency of all headaches?	Approximate x's per day:

	Approximate x's per week:
What is the average duration of all headaches?	About minutes; hours
What is the approximate frequency of **severe** headaches?	Approximate x's per day: Approximate x's per week:
What is the approximate duration of **severe** headaches?	About minutes hours

During times your patient has a headache would your patient generally be precluded from performing even basic work activities and need a break from the workplace?	Yes ☐	No ☐

UPPER EXTREMITY USE WITH MULITPLE LEVEL CERVICAL FUSION

Is there a medical probability that the cervical condition will cause problems with your patient's upper extremities?		Yes ☐	No ☐
If yes, which is the affected extremity:	Right ☐ Left ☐		Both ☐

Identify any signs or symptoms your patient exhibits that affect shoulders, elbows, wrists, hands or fingers:

☐ Tenderness	☐ Paresthesia	☐ Joint warmth
☐ Pain	☐ Soft tissue swelling	☐ Joint deformity
☐ Muscle spasm	☐ Muscle weakness	☐ Reduced grip strength
☐ Redness	☐ Limitation of motion	☐ Muscle atrophy

	Not at all	**Rare** 1-5% day	**Occasionally** up to 1/3rd day	**Frequently** 1/3rd to 2/3rd day	**Continuously** 2/3rd day or more

REACHING: **Over shoulder(s)/head**

	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left

REACHING: **Below shoulder(s)**

	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left

HANDLING: Seizing, holding, grasping, turning, or otherwise working with hand or hands. Fingers are involved only to the extent that they are an extension of the hand, such as to turn a switch or shift automobile gears.

	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left

FINGERING: Picking, pinching, or otherwise working primarily with fingers rather than with the whole hand or arm as in handling.

	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left

Estimate the time in an 8-hour work day claimant can use hands/fingers/arms for the following activities:

	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left
Simple Grasping										
Fine Manipulation										
Repetitive activities										

EXERTIONAL PHYSICAL DEMANDS: (SIT, STAND, WALK)

Estimate # of hours of a work day, 8 hours or otherwise, can claimant be expected to sustain competitive work:

	<1	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Sit									
Stand									
Walk									

EXERTIONAL PHYSICAL DEMANDS: (LIFT, CARRY, PUSH AND PULL)

	LIFT with RIGHT				
	Not at all	Rarely 1-5% day	Occasionally up to 1/3rd day	Frequently 1/3rd to 2/3rd day	Continuously 2/3rd day or more
< 10 pounds					
10 pounds					
11-20 pounds					
21-25 pounds					
	LIFT with LEFT				
	Not at all	Rarely 1-5% day	Occasionally up to 1/3rd day	Frequently 1/3rd to 2/3rd day	Continuously 2/3rd day or more
< 10 pounds					
10 pounds					
11-20 pounds					
21-25 pounds					
	CARRY with RIGHT				
	Not at all	Rarely 1-5% day	Occasionally up to 1/3rd day	Frequently 1/3rd to 2/3rd day	Continuously 2/3rd day or more
< 10 pounds					
10 pounds					
11-20 pounds					
21-25 pounds					
	CARRY with LEFT				
	Not at all	Rarely 1-5% day	Occasionally up to 1/3rd day	Frequently 1/3rd to 2/3rd day	Continuously 2/3rd day or more
< 10 pounds					
10 pounds					
11-20 pounds					
21-25 pounds					
	PUSH/PULL				
	Not at all	Rarely 1-5% day	Occasionally up to 1/3rd day	Frequently 1/3rd to 2/3rd day	Continuously 2/3rd day or more
< 10 pounds					
10 pounds					
11-20 pounds					
21-25 pounds					

NON-EXERTIONAL PHYSICAL DEMANDS

	Not at all	**Rare** 1-5% day	**Occasionally** up to 1/3rd day	**Frequently** 1/3rd to 2/3rd day	Continuously 2/3rd day or more
Climb Stairs					
Balance					
Stoop					
Crouch					

Claimant is restricted from activities involving: (check capacity for each activity)			
	Restricted	Unrestricted	Comments
Hazards (moving machinery, heights)			
Driving Automotive Equipment			
Exposure to Dust, Fumes, Gases			
Changes in Temperature			
Extreme heat			
Extreme cold			
Humidity			
Wetness			
Vibration			

REASONABLE ACTIVITES TO CONTROL AND/OR RELIEVE PAIN

What is the most effective manner for claimant to control or manage his/her pain?		
☐ Take Medications ☐ Apply TENS Unit ☐ Lie Down ☐ Recline ☐ Rest	☐ Apply hot/cold packs ☐ Alternate positions ☐ Avoid prolonged activities ☐ Use of supports ☐ Avoid offending activities	Other:

Allowance to alternate positions:			
A. Will claimant need an allowance to alternate positions at will?	Yes☐	No☐	Comments:
B. Will the allowance to alternate positions include the ability to sit, stand, and walk even if only a few steps and/or stretch?	Yes☐	No☐	

C. Please estimate the number of minutes and/or hours claimant is able to sit, stand, or walk ***at one time without interruption*** before needing to alternate or change positions:

Minutes/hours	<5	Up to 5min	Up to 10min	Up to 15min	Up to 20min	Up to 30min	Up to 45min	Up to 1 hour without a break	Up to 2 hours without a break
Sitting									
Walking									
Standing									

D. Please estimate the length of time needed before claimant can resume sitting, standing and walking

	<1 min	Up to 5 min	Up to 10 min	Up to 15 min	Other:
Sitting					Other:
Walking					Other:
Standing					Other:

LIE DOWN/RECLINE

Is there a reasonable medical probability that claimant will need to take lie down or recline during the workday to relieve or control pain? ☐ Yes ☐ No ☐ Other:
If claimant needs to lie down or recline to relive or control pain can you estimate for how *often* and for *how long* he or she may have to do so? About _____ minutes; every _____hour(s)

UNSCHEDULED BREAKS

Is there a reasonable medical probability that claimant will need to take unscheduled breaks during the workday? ☐ Yes ☐ No ☐ Other:				
If claimant needs to take unscheduled breaks to relieve or control pain can you estimate how *often* and for how long he or she may have to do so? About _____minutes; every _____hour(s)				
How often during a typical workday will claimant experience fatigue or other symptom severe enough to interfere with ***attention and concentration*** needed to perform even simple work tasks as a result of the combination of impairments?				
Not at all	**Rare** 1-5% day	**Occasionally** up to 1/3rd day	**Frequently** 1/3rd to 2/3rd day	**Continuously** 2/3rd day or more
☐	☐	☐	☐	☐
How often during a typical workday will the combination of claimant's impairments interfere with an ability to perform ***sustained and competitive work***?				
Not at all	**Rare** 1-5% day	**Occasionally** up to 1/3rd day	**Frequently** 1/3rd to 2/3rd day	**Continuously** 2/3rd day or more
☐	☐	☐	☐	☐
To what degree can claimant tolerate ***work stress*** as a result of the medical condition(s)?				
Examples of factors that may precipitate work related stress: maintaining speed; precision; persistence and pace; complexity; meeting deadlines; working within a schedule; making decisions; exercising independent judgment; completing tasks; getting to work regularly; remaining at work for a full day.				
☐ Incapable of "low stress" jobs		☐ Capable of low stress jobs		
☐ Moderate stress is okay		☐ Capable of high stress work		
Will claimant's impairments likely to produce "good days" and "bad days"? ☐ Yes ☐ No ☐ Other:				
If yes, please estimate, on average, how many days per month claimant is likely to be absent from work as a result of the impairments or treatment?				
☐ Never ☐ About one day per month ☐ About two days per month		☐ About three days per month ☐ About four days per month ☐ More than four days per month		

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the report accurately describes the information provided to me and except as noted herein, that I believe it to be true. I also declare under the perjury that this physician has no violated section 139.3 of the Labor Code.

My opinions are expressed to a degree of medical probability, unless otherwise stated.

Signature of Physician _____ Date _____

Additional Comments:_____