RESIDUAL FUNCTIONAL CAPACITY DUE TO PAIN

Name:			
Claim #:			
Date of Injury:			
Please Print Name of Medical Evaluator:			
Medical Specialty:			
What is the first date claimant's impairment(s) became "severe" meaning that they caused interference in ADL's or ability to work?		Date:	
When did you begin treating the claimant?		Date:	
How frequently do you see your claimant?		Date:	
Has any medication and/or treatment necessary to relieve and/or control pain of the underlying condition(s) been denied?		Yes☐	No☐
If yes, has the claimant's functionality decreased as a result of the denial?		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:			
Is there a reasonable medical probability that claimant's underlying condition will generate a pain response?		Yes☐	No☐
Can you please list the medical condition(s) and objective findings through diagnostic test, if any, that can reasonably be expected to generate pain:			
If yes, is there a medical probability that claimant will: a. Experience "referred" pain to other body parts?		Yes☐	No☐
b. Experience "deferred" pain after engaging in physical activities?		Yes☐	No☐
Examples where claimant is likely to experience pain?			
☐ Head ☐ Neck ☐ Shoulders ☐ Arms ☐ Wrists ☐ Hands	☐ Fingers ☐ Upper Back ☐ Mid Back ☐ Lower Back ☐ Buttocks ☐ Leg(s)	☐ Knee(s) ☐ Ankle (s) ☐ Foot ☐ Chest ☐ Internal ☐ Groin	Other:
Please describe the quality of claimant's pain:			
☐ Dull ☐ Throbbing ☐ Shooting ☐ Stabbing ☐ Pinching	☐ Sharp ☐ Stinging ☐ Cramping ☐ Radiating ☐ Aching	☐ Tingling ☐ Acute ☐ Chronic ☐ Numbness ☐ Burning	Other:
Will changes in temperature, exposure to cold, humidity or wetness associated with claimant's impairments generate a pain response? ☐ Yes ☐ No ☐ Other:			
Will pain, depending on the frequency, duration and intensity result in functional limitations? ☐ Yes ☐ No ☐ Other:			
In utilizing this form, please assume the following definitions of "degree of limitations:" [Chapter 14.3e of the AMA Guides]			

1. None means no impairment is noted in the functions.
2. Mild implies that any discerned impairment is compatible with most useful functioning.
3. Moderate means that the identified impairments are compatible with some, but not all, useful functioning.
4. Marked is a level of impairment that significantly impedes useful functioning. Taken alone, a marked impairment would not completely preclude functioning, but together with marked limitation in another class, it might limit useful functioning.
5. Extreme means that the impairment or limitation is not compatible with useful function.

Within a reasonable medical probability please evaluate claimant's capacity to perform the following functions over a normal workday and workweek, on an ongoing basis in the presence of chronic, acute and/or variable pain:

Pain can be expected to cause distractions for the following functions:	None	Mild	Moderate	Marked	Extreme
Carry out short and simple instruction.					
Carry out detailed instructions.					
Maintain attention and concentration for extended periods.					
Maintain persistence and pace for extended periods.					
Perform activities within a set schedule; maintain regular attendance and punctuality within customary tolerances.					
Complete a normal workday and workweek without an unreasonable number of rest periods or interruptions due to pain.					
Maintain focus for activities such as reading, writing, and/or computer use or other activities requiring cognitive acuity without distraction due to pain.					

Can episodes of pain become *moderate, moderate to severe,* or *severe*? **[<u>Circle one or more</u>]** 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

Please evaluate claimant's capacity to perform the following functions over a normal workday on an ongoing basis in the presence of **chronic, acute and/or persistent pain:**

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

	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					
Crawl					

UPPER EXTREMITIES

The claimant's dominant extremity is:	RIGHT ☐	LEFT ☐
The claimant's affected extremity is:	RIGHT ☐	LEFT ☐

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

Please estimate claimants capacity to perform the following activities:

	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** while extending hand(s) and arm(s).										
	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left
REACHING: **Below shoulders** while extending hand(s) and arm(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										

If one upper extremity is affected will claimant likely use the uninjured extremity to guard, assist, and massage or rub the injured extremity to relieve pain and discomfort?	☐ Yes	☐ No	☐ Other:

LOWER EXTREMITY IMPAIRMENTS:

With ***prolonged sitting*** should claimant leg(s) be elevated to avoid swelling and/or to reduce pain?	☐ Yes	☐ No	☐ Other:
If yes, can you estimate how *often* he/she may need to elevate the leg(s)? About _____ minutes; every _____hour(s)	☐ Both	☐ Right	☐ Left

If elevation of the leg(s) is required, how ***long*** will the leg(s) require elevation at one time?

Minutes/hours	<5min	5-10	11-15	16-20	21-30	31-45	1 hour	1 ½ hour	Other:
Right									
Left									

Both									
☐ 1-5 inches	☐ Up to 10”	☐ Up to 15”	☐ Up to 20”	☐ Up to 25”	☐ >25 inches				
☐Below Knee	☐ Above Knee	☐ Waist Level	☐Above Heart	☐ Other					

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 from work activity 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 of 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

If not already addressed in prior reports, please provide objective findings, diagnostic test results and diagnoses and all other pertinent factors that support your responses to this questionnaire.

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: _____