RESIDUAL FUNCTIONAL CAPACITY TO LOWER EXTREMITIES

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 denials?									Yes☐	No☐
Does claimant experience any side effects from 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 taking into account 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	Other:				

EXERTIONAL PHYSICAL DEMANDS: (SIT, STAND, WALK)

How many 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									
Drive									

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

	LIFT				
	Not at all	Rarely <5 Min	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 pound					
21-25 pounds					
26-50 pounds					
	CARRY				
	Not at all	Rarely <5 Min	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					
26-50 pounds					
	PUSH/PULL				
	Not at all	Rarely <5 Min	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					
26-50 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 Ladders					
Climb Stairs					
Balance					
Kneel					
Stoop					
Crouch					
Crawl					
Reaching: Over shoulders					
Reaching: Below shoulders					
Handling					
Fingering					

LOWER EXTREMITIES

The claimant's affected lower extremity is:			BOTH ☐	RIGHT ☐	LEFT ☐
FEET: Claimant can use FEET for *repetitive movements*, as in operating foot controls or driving.					
	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
Right					
Left					
Both					
With ***prolonged sitting*** should claimant leg(s) be elevated?				Yes☐	No☐
If elevating the leg(s) is required for **any reason**, how ***long*** should they be elevated?					

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

Considering the response supra, please estimate how ***often*** the leg(s) should be elevated? Approximately every_____minutes; and/or every:_____hour(s)					
If elevating the leg(s) is required for **any reason**, how ***high*** should they be elevated?					
☐ 1-5inches	☐ Up to 10 inches	☐ Up to 15 inches	☐ Up to 20 inches	☐ Up to 25inches	☐ >25 inches
☐Below Knee	☐ Above Knee	☐ Waist Level	☐Above Heart	☐ Other	

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			
Humidity			
Wetness			
Noise			
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 hot/cold packs	Other:
☐ Apply TENS Unit	☐ Alternate positions	
☐ Lie Down	☐ Avoid prolonged activities	
☐ Recline	☐ Use of supports	
☐ Rest	☐ Avoid offending activities	

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

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 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:_____