

FATIGUE RFC

Name:		
Claim #:		
Date of Injury:		
What is the first date at which your patient’s impairment(s) became “severe” meaning that his or her impairment(s) caused interference their ADL’s or ability to work?	Date:	
When did you begin treating the patient?	Date:	
How frequently do you see your patient?	Date:	

Please answer the following questions concerning your patient's disorders and associated health problems.

1. Underlying diagnoses _____
2. Prognosis: _____

[Exertional capacity addresses an individual's limitations and restrictions of physical strength and defines the individual's remaining ability to perform each of seven strength demands: Sitting, standing, walking, lifting, carrying, pushing, and pulling. An exertional limitation is an impairment-caused limitation of any one of these activities.

Non-exertional capacity considers any work-related limitations and restrictions that are not exertional. Therefore, a non-exertional limitation is an impairment-caused limitation affecting such capacities as mental abilities, vision, hearing, speech, climbing, balancing, stooping, kneeling, crouching, crawling, reaching, handling, fingering, and feeling. Environmental restrictions are also considered to be non-exertional.

Thus, it is the nature of an individual's limitations and restrictions, not certain impairments or symptoms that determines whether the individual will be found to have only exertional limitations or restrictions, only non-exertional limitations or restrictions, or a combination of exertional and non-exertional limitations or restrictions. *For example, even though mental impairments often affect non-exertional functions, they may also limit exertional capacity affecting one of the seven strength demands; e.g., from fatigue or hysterical paralysis.* Likewise, symptoms, including pain, are not intrinsically exertional or non-exertional; when a symptom causes a limitation in one of the seven strength demands, the limitation must be considered exertional. (SSR: 96-9p)]

Is there a reasonable medical probability that your patient:

Will experience <i>fatigue</i> due to <i>pain</i> ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:
Will experience <i>fatigue</i> due to <i>depression</i> ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:
Will experience <i>fatigue</i> due to <i>the side effects of medication</i> ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:
Will experience <i>fatigue</i> due to the underlying medical condition(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:
Will experience <i>fatigue</i> due to any other medical condition(s). <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:
Will experience <i>fatigue</i> due to the combination, or the synergistic effect, of multiple factors such as pain, depression, side effects of medication, if any, and the functional limitations of the underlying condition(s) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:

Will your patient experience *fatigue* due to *hyper-somnolence* from any of the following **symptoms and signs**:
(please check)

<input type="checkbox"/> Cataplexy	<input type="checkbox"/> Sinus arrhythmia	<input type="checkbox"/> Hypnagogic phenomenon
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Extreme bradycardia	<input type="checkbox"/> Ventricular tachycardia
<input type="checkbox"/> Atrial flutter	<input type="checkbox"/> Sleep paralysis	<input type="checkbox"/> Excessive daytime sleepiness
<input type="checkbox"/> Cognitive problems	<input type="checkbox"/> Automatic behavior	<input type="checkbox"/> Hypercapnia
<input type="checkbox"/> Sleep apnea:	<input type="checkbox"/> Obstructive	<input type="checkbox"/> Central <input type="checkbox"/> Mixed
<input type="checkbox"/> Other		

REDUCED FUNCTIONALITY DUE TO FATIGUE:

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 1-5% day	Occasionally up to 1/3 rd day	Frequently 1/3 rd to 2/3 rd day	Continuously 2/3 rd day or more
< 10 pounds					
10 pounds					
11-20 pounds					
21-25 pounds					
26-50 pounds					
	CARRY				
	Not at all	Rarely 1-5% day	Occasionally up to 1/3 rd day	Frequently 1/3 rd to 2/3 rd day	Continuously 2/3 rd day or more
< 10 pounds					
10 pounds					
11-20 pounds					
21-25 pounds					
26-50 pounds					
	PUSH/PULL				
	Not at all	Rarely 1-5% day	Occasionally up to 1/3 rd day	Frequently 1/3 rd to 2/3 rd day	Continuously 2/3 rd day or more
< 10 pounds					
10 pounds					
11-20 pounds					
21-25 pounds					
26-50 pounds					

Allowance to alternate positions:									
A. Will claimant need an allowance to alternate positions at will?					Yes <input type="checkbox"/>	No <input type="checkbox"/>	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 <input type="checkbox"/>	No <input type="checkbox"/>			
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:				

UNSCHEDULED BREAKS

Is there a reasonable medical probability that claimant will need to take unscheduled breaks from work activity during the workday? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:
If claimant needs to take unscheduled breaks to relieve or control pain can you estimate how <i>often</i> and for how long he or she may have to do so? About _____ minutes; every _____ hour(s)

LIE DOWN/RECLINE DUE TO FATIGUE

Is there a reasonable medical probability that claimant will need to take lie down or recline from work activity during the workday due to fatigue? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:				
If claimant needs to lie down or recline to relieve or control pain can you estimate for how <i>often</i> and <i>how long</i> may he or she have to do so? About _____ minutes; every _____ hour(s)				
If your patient was placed in a competitive job, identify those aspects of workplace stress that your patient would be unable to perform or be exposed to due to <i>fatigue</i> :				
<input type="checkbox"/> Routine, repetitive tasks at consistent pace				
<input type="checkbox"/> Detailed or complicated task				
<input type="checkbox"/> Strict deadlines				
<input type="checkbox"/> Fast paced tasks (e.g., production line)				
<input type="checkbox"/> Exposure to work hazards (e.g., heights or moving machinery)				
If your patient experiences symptoms, including <i>fatigue</i> , that interfere with the attention and concentration needed to perform even simple work tasks, during a typical workday, please estimate the frequency of interference:				
Not at all	Rare 1-5% day	Occasionally up to 1/3 rd day	Frequently 1/3 rd to 2/3 rd day	Continuously 2/3 rd day or more
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If your patient experiences symptoms, including mental or physical <i>fatigue</i> manifested in <u>somnolence (decreased wakefulness)</u> that interfere with the ability needed to perform even simple work tasks, during a typical workday, please estimate the frequency of interference:				
Not at all	Rare	Occasionally	Frequently	Continuously
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If your patient experiences symptoms, including mental or physical <i>fatigue</i> manifested in <u>general decrease of attention</u> , not necessarily including sleepiness that interfere with the ability needed to perform even simple work tasks, during a typical workday, please estimate the frequency of interference:				
Not at all	Rare	Occasionally	Frequently	Continuously
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If your patient experiences symptoms, including <u>excessive daytime sleepiness (EDS) characterized by persistent sleepiness</u> , and often a <u>general lack of energy and fatigue</u> even after apparently adequate night time sleep that interfere with the ability needed to perform even simple work tasks, during a typical workday, please estimate the frequency of interference:				
Not at all	Rare	Occasionally	Frequently	Continuously
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Will claimant's impairments likely to produce "good days" and "bad days"? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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?				
<input type="checkbox"/> Never		<input type="checkbox"/> About three days per month		
<input type="checkbox"/> About one day per month		<input type="checkbox"/> About four days per month		
<input type="checkbox"/> About two days per month		<input type="checkbox"/> More than four days per month		

MENTAL ACTIVITIES THAT MAY BE ADVERSLY AFFECTED BY FATIGUE

Each mental activity is to be evaluated within the context of the individual's capacity to sustain that activity over a normal workday and workweek, on an ongoing basis. Chapter 14.3e Class of Impairments Due to Mental and Behavioral Disorders

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.

	None	Mild	Moderate	Marked	Extreme
Ability to perform tasks that require constant concentration, such as driving a vehicle to and from work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to perform tasks that require constant concentration, such as operating machinery, equipment or electric operated tools.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to maintain concentration and attention for extended periods (the approximately 2-hour segments between arrival and first break, lunch, second break, and departure).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Residual Functional Capacity

Ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to sustain an ordinary routine over an eight hour work day.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to be aware of normal hazards and take appropriate precautions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to complete a normal workday and workweek without interruptions from <i>fatigue</i> and perform at a consistent pace without an unreasonable number and length of rest periods.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The ability to carry out repetitive and prolonged activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The ability to carry out detailed instructions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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: _____