DIABETES MELLITUS RESIDUAL FUNCTIONAL CAPACITY

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:		
Within a reasonable degree of medical probability:									
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 indentified? Hour(s) each day:	<1	1	2	3	4	5	6	7	8

Identify all of your patient's *symptoms:*		
☐ fatigue	☐ general malaise	☐ extremity pain and numbness
☐ difficulty walking	☐ muscle weakness	☐ loss of manual dexterity
☐ episodic vision blurriness	☐ retinopathy	☐ diarrhea
☐ bladder infections	☐ kidney problems	☐ frequency of urination
☐ bed wetting	☐ hot flashes	☐ sweating
☐ infections / fevers	☐ psychological problem	☐ difficulty thinking concentration
☐ excessive thirst	☐ abdominal pain	☐ dizziness / loss of balance
☐ rapid heartbeat / chest pain	☐ vascular disease / leg cramping	☐ headaches
☐ swelling	☐ insulin shock / coma	☐ hyper / hypoglycemic attacks
☐ chronic skin infections	☐ nausea / vomiting	☐ sensitivity to light-heat-cold
☐ other		

<u>Excessive thirst and increased urination:</u>
Diabetes may lead to excessive thirst and increased urination.

Does your patient have urinary frequency?	☐ Yes	☐ No
If yes, please estimate approximately how often your patient must urinate:		
☐ 1 time every 2 hours	☐ 2 times every 2 hours	☐ 3 times every 2 hours
☐ 4 times every 2 hours	☐ 5 times or more every 2 hours	Other:
Diabetes may lead to fatigue.	☐ Yes	☐ No
Does your patient experience fatigue as a result of diabetes?	☐ Yes	☐ No

Assume a scale of 1-5 with 1 meaning no to minimal fatigue and 5 extreme fatigue precluding ADLs and/or work.

☐ None to minimal Fatigue	☐ Slight	☐ Moderate Fatigue Able to perform ADL's and work but with marked handicap	☐ Moderate to Severe	☐ Severe Fatigue Unable to perform ADL's and work

(a) If your patient experiences severe fatigue, describe when it is most likely to occur:

☐ At rest	☐ With some physical exertion	☐ With moderate physical exertion	☐ Only with extreme physical exertion

(b) Frequency of severe level of fatigue:			
☐ Daily	☐ One or more times a week	☐ One or more times a month	Other:

Weight gain or loss:		
Has your patient experienced weight gain or loss?	☐ Yes	☐ No

If yes, how much weight gain or loss has your patient experienced from the date of her/his first visit:					
Weight first visit:		Weight last visit:		Gain/ Loss:	

Blurred vision: Diabetes symptoms may involve vision loss.		
Has your patient experienced vision loss?	☐ Yes	☐ No

How often can your patient perform work activities involving the following?

	Never	**Rarely**	**Occasionally**	**Frequently**	**Constantly**
Near Acuity					
Far Acuity					
Depth Perception					
Accommodation					
Color Vision					
Field of Vision					

Diagnoses:_____

Prognosis: _____

After best correction visual acuity right eye: _____

After best correction visual acuity left eye:_____

Describe contraction of peripheral visual fields in the better eye:

Describe your patient's vision ***symptoms***:_____

Tingling hands and feet: Excess sugar in the blood can lead to nerve damage. This can lead to tingling and loss of sensation in the hands and feet, as well as burning pain in the arms, hands, legs and feet.		
Has your patient experienced tingling in his/her hands and/or feet?	☐ Yes	☐ No

If your patient experiences tingling in his/her hands and feet, how often will this occur?				
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)
☐	☐	☐	☐	☐

Will the tingling in the hands affect your patient's ability to perform fine dexterity?	☐ Yes	☐ No

If yes, how often will this occur?				
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)
☐	☐	☐	☐	☐

Is your patient a malingerer?	☐ Yes	☐ No

Does your patient exaggerate, magnify or embellish his/her symptoms?	☐ Yes	☐ No
Does stress play a roll in bringing on your patient's symptoms?	☐ Yes	☐ No

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 pounds					
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					
Feeling					

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

☐ 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	

	(# of hours in an 8-hour day)									Duration (# of continuous minutes)							
	<1	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	<5 min	5-10	11-15	16-20	21-30	31-45	46-60	Other
Write																	
Keyboard																	
Mouse																	

NECK/HEAD/CERVICAL REGION for repetitive actions such as: (check capacity for each activity)

Physical Activity	(# of hours in an 8-hour day)									Duration/Tolerance							
	<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																	

FINE MANIPULATION

What degree of pain, if any, will claimant experience when performing ***competitive*** work requiring fine manipulation and/or fine dexterity with the affected upper extremity (ies)? ☐ Mild ☐ Slight ☐ Moderate ☐ Severe ☐ Other:

GROSS MANIPULATION

What degree of pain, if any, will the claimant experiences when performing ***competitive*** work requiring gross manipulation with the affected upper extremity (ies)? ☐ Mild ☐ Slight ☐ Moderate ☐ Severe ☐ 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			
Extreme heat			
Extreme cold			
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	

Will claimant need allowance to alternate positions at will?	YES☐	NO☐	Comments:

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 can sit, stand, or walk ***at one time without interruption*** before needing to alternate or change positions:

Capacity for:	<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									

If claimant must **alternate positions** after sitting, walking, or standing the ***maximum duration*** estimated above, can you estimate of the length of time needed before claimant can resume sitting, walking, or standing?

Break time	<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 from work activity during the workday? ☐ Yes ☐ No ☐ Other:
If claimant needs to take unscheduled beaks to relive 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 three days per month
☐ About one day per month	☐ About four days per month
☐ About two days per month	☐ More than four days per month

Please describe any other limitations (such as psychological limitations, limited vision, difficulty hearing, etc.) that would affect your patient's ability to work at a regular job on a sustained basis:

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: _____