RESIDUAL FUNCTIONAL CAPACITY (VERTIGO) DIZZINESS/IMBALANCE

Name:	
Claim #:	
Date of Injury:	

Please Print Name of Medical Evaluator:

Medical Specialty:

Has any medication and/or treatment necessary to relieve and/or control 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 claimant reasonably be expected to engage in sustained competitive work 8 hours a day 5 days a week considering his/her functional limitations due to episodes of dizziness/imbalance?	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:

Does your patient experience episodes of dizziness/imbalance?	Yes☐	No☐

If yes, what diagnosis is this dizziness/imbalance related to?

What is the average frequency of your patient's dizziness/imbalance episodes?

Approximately (x's) _____ per day

Approximately (x's) _____ per week

How long does a typical episode last?

About _____minutes

About _____hours

Does your patient always have a warning of impending dizziness/imbalance?	Yes☐	No☐

If yes, how long is it between the warning and the onset of the dizziness/imbalance? About minutes

What factors may trigger the on-set of dizziness/imbalance?

☐ Walking: how long?_____Minutes/_____Hours	☐ Physical exertion
☐ Standing: how long?_____Minutes/_____Hours	☐ Mental exertion
☐ Rising from a seated position	☐ Temperature extremes
☐ Rising from laying down	☐ Moving the head
☐ Stress	☐ Other:

Please identify symptoms associated with your patient's dizziness/imbalance episodes?

☐Nausea/vomiting	☐Sensitivity to noise
☐ Visual disturbances	☐ Fatigue/exhaustion

☐ Malaise ☐ Mood changes ☐ Photosensitivity ☐ Mental confusion/inability to concentrate ☐ A false sense of motion or spinning ☐ Double vision	☐ Hot flashes ☐ Falling ☐ Feeling dizzy ☐ Difficulty breathing ☐ Headaches ☐ Other:

After the episode ends, are there any after effects? *Check those that apply:*

☐ Confusion ☐ Exhaustion ☐ Irritability ☐ Headache	☐ Severe headache ☐ Muscle strain ☐ Paranoia ☐ Other:

How long after an episode do these after effects last? About minutes hours

Will your patient need more supervision at work than an unimpaired worker?	Yes☐	No☐
Can your patient work at heights?	Yes☐	No☐
Can your patient work with power machines that require an alert operator?	Yes☐	No☐
Can your patient operate a motor vehicle?	Yes☐	No☐
Can your patient take a bus alone?	Yes☐	No☐

Does your patient have any associated mental problems as a result of dizziness/imbalance? *Check those that apply:*

☐ Depression ☐ Short attention span ☐ Irritability ☐ Memory problem	☐ Social isolation ☐ Behavior extremes ☐ Poor self-esteem ☐ Other:

Is it reasonable to expect episodes dizziness/imbalance to occur at times spontaneously, unpredictably and/or without provocation?	Yes☐	No☐
If yes, how often?		
During episodes dizziness/imbalance is it recommended that your patient sit or lie down?	Yes☐	No☐

LIE DOWN/RECLINE

Is there a reasonable medical probability your patient will need to lie down or recline during the workday due to episodes of dizziness/imbalance? ☐ Yes ☐ No ☐ Other:

If your patient needs to lie down or recline due to episodes of dizziness/imbalance can you estimate 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 your patient will need to take unscheduled breaks during the workday due to episodes of dizziness/imbalance? ☐ Yes ☐ No ☐ Other:

If your patient needs to take unscheduled breaks to due to episodes of dizziness/imbalance 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 your patient experience fatigue or other symptom severe enough to interfere with ***attention and concentration*** needed to perform even simple work tasks as a result of dizziness/imbalance?

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*** as a result of dizziness/imbalance?				
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 your patient tolerate ***work stress*** as a result of this medical condition?	
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:_____