PHYSICAL RESIDUAL FUNCTIONAL CAPACITY ASSESSMENT

Patient Name:_____

Patient SSN:_____

IDENTIFICATION OF DIAGNOSES

Please identify the diagnoses which support the opinions that you offer in this assessment:

1. _____

2. _____

3. _____

4. _____

5. _____

Due to these conditions, it is my opinion that within a reasonable degree of medical certainty, this individual would have the following functional limitations if placed in a **competitive** work situation on a full time basis (regular and continuing 8 hours a day, 5 days per week).

A. Please indicate how long your patient can sit and stand/walk ***total in an 8-hour working day*** (with normal breaks):

Sit	**Stand/walk**	
☐	☐	less than 2 hours
☐	☐	about 2 hours
☐	☐	about 4 hours
☐	☐	at least 6 hours

B. Does your patient need a job that permits shifting positions at will from sitting, standing or walking? ☐ Yes ☐ No

C. Will your patient occasionally need to take unscheduled breaks during a working day? ☐ Yes ☐ No

For this and other questions on this form, "rarely" means 1% to 5% of an 8-hour working day; "occasionally" means 6% to 33% of an 8-hour working day; "frequently" means 34% to 66% of an 8-hour working day.

D. How many pounds can your patient lift and carry in a competitive work situation?

	Never	Rarely	Occasionally	Frequently
Less than 10 lbs.	☐	☐	☐	☐
10 lbs.	☐	☐	☐	☐
20 lbs.	☐	☐	☐	☐
50 lbs.	☐	☐	☐	☐

E. How often can your patient perform the following activities?

	Never	Rarely	Occasionally	Frequently
Crouch	☐	☐	☐	☐
Stoop (bend)	☐	☐	☐	☐
Twist	☐	☐	☐	☐
Climb stairs	☐	☐	☐	☐
Kneel	☐	☐	☐	☐

F. Does your patient have significant limitations with reaching, handling or fingering?
☐ Yes ☐ No

If yes, please describe: _____

G. How much is your patient likely to be *"off task"*? That is, what percentage of a typical workday would your patient's symptoms likely be severe enough to interfere with *attention and concentration* needed to perform even simple work tasks?

☐ 0% ☐ 5% ☐ 10% ☐ 15% ☐ 20% ☐ 25% or more

H. Are your patient's impairments likely to produce "good days" and "bad days"?

☐ Yes ☐ No

If yes, assuming your patient was trying to work full time, please estimate, on the average, how many days per month your patient 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

I. Are your patient's symptoms as demonstrated by signs, clinical findings and laboratory or test results *reasonably consistent* with the diagnoses and functional limitations described above in this evaluation?

☐ Yes ☐ No

If no, please explain: _____

J. How often can your patient tolerate the following environmental exposures:

	Never	Rarely	Occasionally	Frequently
Temperature Extremes	☐	☐	☐	☐
Dust	☐	☐	☐	☐
Humidity	☐	☐	☐	☐
Hazards (heights and moving machinery)	☐	☐	☐	☐
Fumes, Odors, Chemicals	☐	☐	☐	☐

K. Have your patient's impairments and their effects lasted or can they be expected to last for a continuous period of at least 12 months?

☐ Yes ☐ No

EXPLANATION OF OPINION:

Please attach a report or discuss below: a) the nature and onset date of the patient's symptoms; b) the clinical and objective findings supporting your opinion; c) the patient's response to treatment and any side-effects; and d) the prognosis.

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DATE

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Medical source's printed name

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Medical source's signature

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Medical source's degree