

**RESIDUAL FUNCTIONAL CAPACITY (RFC)**

<b>Name:</b>	
<b>Claim #:</b>	
<b>Date of Injury:</b>	

	YES	NO
Can the patient work 8 hours a day?	<input type="checkbox"/>	<input type="checkbox"/>

Hour(s):	1	2	3	4	5	6	7	8
If no, in an 8 hour day, how many hours can the patient work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(In the event client cannot work 8 hours a day, 40 hours a week, SSR 96-8p will apply.)

	YES	NO	WALKER	CANE	OTHER	If other, please list device:
Assistive Devices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	YES				NO	
Has one been medically prescribed?	<input type="checkbox"/>				<input type="checkbox"/>	

**Lying Down:**

	YES	NO
In your opinion, will the patient be required to lie down during the day to rest as a result of his or her medical condition?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how often will the patient be required to lie down or recline to rest during an 8 hour day?		
Durations of rest break(s)?		

**Side Effects of Medication:**

	YES	NO
Is the patient taking proscribed medication?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Medications:</b> (please list medications)	<hr/> <hr/>	
	YES	NO
If yes, is there a reasonable medical probability that the patient will experience side effects from the medication?	<input type="checkbox"/>	<input type="checkbox"/>

Functional Capacity Evaluation

	Dizziness	Fatigue	Drowsiness	Difficulty Maintaining Concentration	Reduced short term memory	Constipation	Mental/Mood Changes	Blurry Vision	Nausea	Vomiting	Other	If other, please list other side effect(s): _____ _____ _____
If yes, what in your opinion is the side effect(s) the patient will experience?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ _____

	<b>Right</b>	<b>Left</b>
The patient's dominant extremity is:	<input type="checkbox"/>	<input type="checkbox"/>
The patient's affected extremity is:	<input type="checkbox"/>	<input type="checkbox"/>

**EXERTIONAL PHYSICAL DEMANDS: (Includes: Sit, stand, walk, lift, carry, push and pull)**

How many hours of an 8-hour work day can the client: (check capacity for each activity)															
Physical Activity	# of hours in an 8-hour day								Duration/Tolerance						Comments
	1	2	3	4	5	6	7	8	5-10 min	11-20 min	21-30 min	31-40 min	41-50 min	51-60+ min	
Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

(If patient cannot sit for up to 6 hours of an 8 hour day and stand and/or walk for up to 2 hours of an 8 hour day SSR 96-9P applies.)

**Breaks during a work day (duration)**

(Please refer to the hours in a day and/or duration before requiring a break and the length of the break. For example:

Applicant can sit for a total of 4 hours in a day.

Applicant can tolerate sitting for 30-40 minutes.

Applicant will require a break after 30-40 minutes of sitting for "Less than 5 minutes.")



## Functional Capacity Evaluation

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**PUSH**

Client is able to: (please check for RIGHT and LEFT sides)

	Not at all		Occasionally (up to 1/3 <sup>rd</sup> day)		Frequently (1/3 <sup>rd</sup> to 2/3 <sup>rd</sup> day)		Continuously (2/3 <sup>rd</sup> day or more)	
	Right	Left	Right	Left	Right	Left	Right	Left
<b>Push:</b>								
Up to 10 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11-20 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21-30 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31-50 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51-100 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PULL**

Client is able to: (please check for RIGHT and LEFT sides)

	Not at all		Occasionally (up to 1/3 <sup>rd</sup> day)		Frequently (1/3 <sup>rd</sup> to 2/3 <sup>rd</sup> day)		Continuously (2/3 <sup>rd</sup> day or more)	
	Right	Left	Right	Left	Right	Left	Right	Left
<b>Pull:</b>								
Up to 10 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11-20 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21-30 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31-50 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51-100 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**NONEXERTIONAL PHYSICAL DEMANDS****CLIMBING**

Ascending or descending ladders, stairs, scaffolding, ramps, poles, and the like, using feet and legs or hands and arms. Body agility is emphasized. Describe in Physical Demands comments section in terms of height, steepness, duration, and type of structure climbed.

Physical Activities	Frequency			
	Not at all	Occasionally (up to 1/3 <sup>rd</sup> day)	Frequently (1/3 <sup>rd</sup> to 2/3 <sup>rd</sup> day)	Continuously (2/3 <sup>rd</sup> day or more)
<b>Climb</b>				
Ladders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**BALANCING**

Maintaining body equilibrium to prevent falling when walking, standing, crouching, or running on narrow, slippery, or erratically moving surfaces; or maintaining body equilibrium when performing gymnastic feats. Describe in Physical Demands comments section in terms of type or condition of surface and activities during which balance must be maintained.

Physical Activities	Frequency			
	Not at all	Occasionally (up to 1/3 <sup>rd</sup> day)	Frequently (1/3 <sup>rd</sup> to 2/3 <sup>rd</sup> day)	Continuously (2/3 <sup>rd</sup> day or more)
<b>Balance</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



## Functional Capacity Evaluation

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**HANDLING**

Seizing, holding, grasping, turning, or otherwise working with hand or hands. Fingers are involved only to the extent that they are an extension of the hand, such as to turn a switch or shift automobile gears.

Client is able to: (please check for RIGHT and LEFT sides)

	Not at all		Occasionally (up to 1/3 <sup>rd</sup> day)		Frequently (1/3 <sup>rd</sup> to 2/3 <sup>rd</sup> day)		Continuously (2/3 <sup>rd</sup> day or more)	
	Right	Left	Right	Left	Right	Left	Right	Left
<b>Handling</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**FINGERING**

Picking, pinching, or otherwise working primarily with fingers rather than with the whole hand or arm as in handling.

Client is able to: (please check for RIGHT and LEFT sides)

	Not at all		Occasionally (up to 1/3 <sup>rd</sup> day)		Frequently (1/3 <sup>rd</sup> to 2/3 <sup>rd</sup> day)		Continuously (2/3 <sup>rd</sup> day or more)	
	Right	Left	Right	Left	Right	Left	Right	Left
<b>Fingering</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**FEELING**

Perceiving attributes of objects, such as size, shape, temperature, or texture, by touching with skin, particularly that of fingertips.

Client is able to: (please check for RIGHT and LEFT sides)

	Not at all		Occasionally (up to 1/3 <sup>rd</sup> day)		Frequently (1/3 <sup>rd</sup> to 2/3 <sup>rd</sup> day)		Continuously (2/3 <sup>rd</sup> day or more)	
	Right	Left	Right	Left	Right	Left	Right	Left
<b>Feeling</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**FEET**

Client can use FEET for repetitive movements, as in operating foot controls or driving.

Foot	Not at All	If yes, what is the frequency?		
		Occasionally (up to 1/3 <sup>rd</sup> day)	Frequently (1/3 <sup>rd</sup> to 2/3 <sup>rd</sup> day)	Continuously (2/3 <sup>rd</sup> day or more)
<b>Right</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Left</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Both</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Functional Capacity Evaluation

**HANDS**

Client can use HANDS for repetitive actions such as: (check capacity for each activity)						
	Simple Grasping		Pushing & Pulling		Fine Manipulation	
	Yes	No	Yes	No	Yes	No
Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Client can use HANDS for repetitive actions such as: (check capacity for each activity)																		
	# of hours in an 8-hour day								Duration (# of continuous minutes)									
	1	2	3	4	5	6	7	8	1-5 min	6-11 min	12-17 min	18-23 min	24-29 min	30-35 min	36-41 min	42-47 min	48-53 min	54-59 min
Write	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keyboard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:																		

Client can use 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						Comments
	1	2	3	4	5	6	7	8	5-10 min	11-20 min	21-30 min	31-40 min	41-50 min	51-60+ min	
Neck Flexion/Extension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neck Rotation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Client is restricted from activities involving: (check capacity for each activity)			
	Restricted	Unrestricted	Comments
Unprotected Heights	<input type="checkbox"/>	<input type="checkbox"/>	
Moving Machinery	<input type="checkbox"/>	<input type="checkbox"/>	
Changes in Temperature	<input type="checkbox"/>	<input type="checkbox"/>	
Driving Automotive Equipment	<input type="checkbox"/>	<input type="checkbox"/>	
Exposure to Dust, Fumes, Gases	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

Functional Capacity Evaluation

Patient needs to change positions?	At Will		Other	Comments			
	YES <input type="checkbox"/>	NO <input type="checkbox"/>					<input type="checkbox"/>
Minutes:		10	20	30	40	50	60
If yes to above, frequently will your patient need to alternate positions?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

[The RFC assessment must be specific as to the frequency of the individual's need to alternate sitting and standing SSR 96-9p]

How often during a typical workday is your patient's experience of fatigue or other symptom severe enough to interfere with **attention and concentration** needed to perform even simple work tasks?

Never	Rarely	Occasionally	Frequently	Constantly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

To what degree can your patient tolerate work stress?

<input type="checkbox"/> Incapable of even "low stress" jobs	<input type="checkbox"/> Capable of low stress jobs
<input type="checkbox"/> Moderate stress is okay	<input type="checkbox"/> Capable of high stress work

Please explain the reasons for our conclusion:

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Will your patient sometimes need to take unscheduled breaks during an 8-hour working day?

Yes <input type="checkbox"/>	No <input type="checkbox"/>
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If yes, a) how often do you think this will happen?

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b) How long (on average) will your patient have to rest before returning to work? \_\_\_\_\_

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.

Signature of Physician \_\_\_\_\_

Date \_\_\_\_\_