MEDICAL OPINION RE: ABILITY TO DO WORK-RELATED ACTIVITIES (PHYSICAL)

NAME: ____________________________________ SSN: ___________________________ DOB: _________________

To determine your patient's ability to do *work-related activities on a day-to-day basis in a regular work setting*, please give us your opinion -- **based on your examination** -- of how your patient's physical capabilities are affected *by the impairment(s)*. Do not consider your patient's age, sex or work experience. Consider the medical history, the chronicity of findings (or lack thereof), symptoms *(including differing individual tolerances for pain, etc.)*, and the expected duration of any work-related limitations.

For each activity shown below:

(1) Indicate your patient's ability to perform the activity; and

(2) Identify the particular medical findings (e.g., physical examination findings, x-ray findings, laboratory test results, history, symptoms (including pain), etc.) that support your opinion regarding any limitations.

IT IS IMPORTANT THAT YOU RELATE PARTICULAR MEDICAL FINDINGS TO ANY REDUCTION IN CAPACITY; THE USEFULNESS OF YOUR OPINION DEPENDS ON THE EXTENT TO WHICH YOU DO THIS.

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1. Maximum ability to lift and carry on an *occasional* basis (no more than 1/3 of an 8-hour day).

   ☐ No limitation ☐ 100# ☐ 50# ☐ 20# ☐ 10# ☐ less than 10#

2. Maximum ability to lift and carry on a *frequent* basis (1/3 to 2/3 of an 8-hour day).

   ☐ No limitation ☐ 50# ☐ 25# ☐ 10# ☐ less than 10#

3. Maximum ability to stand and walk (with normal breaks) during an 8-hour day.

   ☐ No limit ☐ about 6 hrs. ☐ about 4 hrs. ☐ about 3 hrs. ☐ about 2 hrs. ☐ less than 2 hrs.

4. Maximum ability to sit (with normal breaks) during an 8-hour day.

   ☐ No limit ☐ about 6 hrs. ☐ about 4 hrs. ☐ about 3 hrs. ☐ about 2 hrs. ☐ less than 2 hrs.

5. If your patient must periodically alternate sitting, standing or walking to relieve discomfort:

   How long can your patient ***sit*** before changing position? 0 5 10 15 20 30 45 60 90 Minutes

   How long can your patient ***stand*** before changing position? 0 5 10 15 20 30 45 60 90 Minutes

   How ***often*** must your patient ***walk around***? Frequency: 0 5 10 15 20 30 45 60 90 Minutes

   How ***long*** must your patient ***walk each time***? Duration: 0 5 10 15 20 30 45 60 90 Minutes

   Does your patient need the opportunity to shift ***at will*** from sitting or standing/walking? ☐ Yes ☐ No

6. *Will your patient sometimes need to lie down at unpredictable intervals during an 8 hour working shift? ☐Yes ☐No*

   If yes, how often do you think this will happen? ____________________________

7. What medical findings support the limitations described above? ____

8. How often can your patient perform the following *postural activities*?

	*Frequently	**Occasionally	Never
Twist	☐	☐	☐
Stoop (Bend)	☐	☐	☐
Crouch	☐	☐	☐
Climb stair	☐	☐	☐
Climb ladders	☐	☐	☐

***Frequently:** from 1/3 to 2/3 of an 8 hour day
****Occasionally:** from very little up to 1/3 of an 8 hour day

What medical findings support this? ____

9. Are the following *PHYSICAL FUNCTIONS* affected by the impairment?

Reaching (including overhead) ☐ Yes ☐ No
Fingering (fine manipulation) ☐ Yes ☐ No
Pushing/pulling ☐ Yes ☐ No
Handling (gross manipulation) ☐ Yes ☐ No
Feeling ☐ Yes ☐ No

A. How are these physical functions affected? ____

B. What medical findings support this? ____

10.

ENVIRONMENTAL RISTRICTIONS	**NO RESTRICTION**	**AVOID CONCENTRATED EXPOSURE**	**AVOID EVEN MODERATE EXPOSURE**	**AVOID ALL EXPOSURE**
Extreme cold	☐	☐	☐	☐
Extreme heat	☐	☐	☐	☐
High humidity	☐	☐	☐	☐
Fumes, odors, dusts, gases	☐	☐	☐	☐
Perfumes	☐	☐	☐	☐
Soldering fluxes	☐	☐	☐	☐
Solvents/cleaners	☐	☐	☐	☐
Chemicals	☐	☐	☐	☐
List other irritants or allergens: ________________________	☐	☐	☐	☐

11. State any other work-related activities which are affected by the impairment such as need for assistive device for ambulation, need to elevate leg, limits on kneeling, crawling, balancing, seeing, hearing or speaking, or limitations related to a mental impairment. What medical findings support this?

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12. On the average, how often do you anticipate that your patient's impairments or treatment would cause your patient to be absent from work?

☐ 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

____
Date

____
Physician's Signature

____
Printed Name