Residual Functional Capacity Form

Patient: _____ SS #: _____

Date of Birth:_____

Dear Doctor:_____

Please respond to the following questions regarding your patients' disability. This will be used as medical evidence for a social security disability claim or a private long term disability claim.

Please be specific with regards to your patients' medical ailments and how they affect his or her daily activities both at work and at home:

1. With regards to your contact with the patient, please describe the frequency and purpose:

2. Please describe the patients' symptoms as completely as possible:

3. Please state all clinical findings and any medical test results and/or laboratory results:

4. What is your diagnosis of the patients symptoms and test results?:

5. Please describe any treatment done so far and the results of treatment:

6. What is your prognosis for this patient?:

7. Would you expect the patients disability or impairment to last one year or more, or has it already lasted one year?:

Yes _____ No _____

8. Does the disability or impairment prevent the patient from standing for six to eight hours?:

Yes _____ No _____

Can the patient stand at all, and if so for how long?

9. Does the disability or impairment prevent the patient from sitting upright for six to eight hours?

Yes _____ No _____

Can the patient stand at all, and if so for how long?

10. If the patient cannot stand and/or sit upright for six to eight hours, what is the reason?:

11. Does the disability or impairment require the patient to lie down during the day?

Yes _____ No _____

If the answer is yes please explain why:

12. How far can the patient walk non-stop?:

13. Please check the frequency with which the patient can perform the following activities:

Percentage of Time	**Rarely – 0-30%**	**Frequently- 30-70%**	**Consistently – 70-100%**
Reach Up Above Shoulders			
Reach Down to Waist Level			
Reach Down Towards Floor			
Carefully Handle Objects			
Handle with Fingers			

14. In pounds, how much weight can the patient lift and carry during an eight hour period?

_____ Less than 5 _____5-10 _____11-20 _____21-50 _____over 50

15. In pounds, how much weight can the patient lift and carry regularly/daily?

____ Less than 5 _____5-10 _____11-20 _____21-50 _____over 50

16. Does the patients disability or impairment prevent the him or her from performing certain motions such as lifting, pulling, holding objects, etc.?:

17. Does the patient have any difficulty performing the motions below? (Please include any range of motion information):

Bending _____

Squatting _____

Kneeling _____

Turning any parts of the body _____

18. Would the patients disability or impairment prevent him or her from travelling alone? Yes _____ No _____Why?

19. Are there any other factors not addressed in the above questions that you believe may affect the patients' ability to work, or function normally in daily life?

20. If the patient has any complaints of pain, please address the following questions:

What is the nature of the pain?

How frequent is the pain?

How would you describe the level of pain?

How would you rate the patients' creditability with regards to claims of pain?

Is there an objective medical reason for the pain?

21. Given your experience with the patient, your diagnosis and the patients disability or impairment, do you believe he or she could continue or resume work at current or previous employment?

Yes _____ No _____

If not, please explain why:

Is there other work the patient could do given his or her skills and disability or impairment?

22. How would you expect the patients diagnosis/disability to change over time?:

____ Disability is Not Likely to Change

____Disability is Temporary: From: _____To: _____

23. When would you expect the patient to be able to return to work, with and/or without any restrictions?:

Please enclose all relevant medical, clinical and laboratory records you have for this patient, and use the space below for any additional comment or information you feel is relevant.

Date Report Completed: _____

Signature of Physician: _____

Physician Name: _____

Address: _____

Telephone: _____

Specialty: _____