Medical Opinion of Ability to Perform Work-Related Activities (PHYSICAL)

PATIENT: _____

We need your help to determine what your patient's physical capabilities are in a regular work setting: forty (40) hours a week or an equivalent work schedule.

Please give us you professional opinion of what the individual can still do despite his/her impairment(s). Consider the medical history, the chronicity of findings (or the lack of), diagnosis, prescribed treatment and response, and prognosis.

THE STRENGTH OF YOUR OPINION DEPENDS ON YOUR ABILITY TO STATE THE MEDICAL BASIS FOR YOUR PATIENT'S LIMITATIONS.

DIAGNOSIS: What is your patient's diagnosis?

_____

_____

_____

1 Based on the diagnosis, related symptoms and response to treatment, please state your opinion of the number of hours your patient may be **able to work**:

____ hours a day (8 maximum) or ____ hours a week (40 maximum)

2. Of that time, how long can your patient **sit, stand or walk** each day?

	At One Time Without Interruption	Total Per Day
SIT	5 15 30 45 60 90 120 minutes	0 1 2 3 4 5 6 7 8 hours
STAND/WALK	5 15 30 45 60 90 120 minutes	0 1 2 3 4 5 6 7 8 hours

Does your patient need the option to **sit, stand or walk at will**? YES NO

Does your patient need to **lie down** during 8 hour working day? YES NO

If yes, **how often**? Every 5 15 30 45 60 90 Minutes

For how long? 5 or less 10 15 Minutes

Does your patient need the option to take **unscheduled breaks**? YES NO

If yes, **how often**? Every 5 15 30 45 60 90 Minutes

For how long? 5 or less 10 15 Minutes

3 On average, how often is your patient likely to be **absent** from work as a result of these limitations or due to treatment?

Estimated Absences: <1x 1x 2x 3x 4x +4x per month

4 Describe your patient's abilities in the following areas:

	Occasionally (0-33% of an 8 hour day)	Frequently (34-66% of an 8 hour day)
LIFT / CARRY	5 or less 10 20 50 pounds	5 or less 10 20 50 pounds
	At One Time Without Interruption	**Total Per Day**
REACH	5 15 30 45 60 90 120 minutes	0 1 2 3 4 5 6 7 8 hours
HANDLE	5 15 30 45 60 90 120 minutes	0 1 2 3 4 5 6 7 8 hours
FINGER	5 15 30 45 60 90 120 minutes	0 1 2 3 4 5 6 7 8 hours
TWIST		0 1 2 3 4 5 6 7 8 hours
BEND		0 1 2 3 4 5 6 7 8 hours
CROUCH		0 1 2 3 4 5 6 7 8 hours
KNEEL		0 1 2 3 4 5 6 7 8 hours
CLIMB STAIRS		0 1 2 3 4 5 6 7 8 hours

5 Please describe what limitation your patient has to these environmental factors.

	NO RESTRICTION	AVOID CONCENTRATED EXPOSURE	AVOID EVEN MODERATE EXPOSURE	AVOID ALL EXPOSURE
Extreme Cold				
Extreme Heat				
High Humidity				
Fumes Odors Dusts Gases				
Noise				
Chemicals				
Vibration				
Wetness				
Unlevel Ground				
Heights				
Moving Machinery				

6 What is the effective date of these limitations? _____

By my signature below, I affirm the foregoing is based upon my objective findings and not solely on my patient's subjective comments.

_____ _____
Signature Date

_____ _____
Name (please print legibly) Medical Specialty