MEDICAL OPINION RE: ________________________________
ABILITY TO DO WORK-RELATED ACTIVITIES

TO:
NAME:
SSN:

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 of how your patient's physical capabilities are affected.

Do not consider your patient's age, sex or work experience. Consider the medical history, onset of medical signs, medical findings, symptoms and any work-related limitations.

1. LIFTING AND CARRYING. Is your patient's ability to lift and carry impaired?

   Yes. No. If yes, please specify:

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

      100 lbs 50 lbs 20 lbs 10 lbs Less than 10 lbs

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

      50 lbs 25 lbs 10 lbs Less than 10 lbs

2. STANDING AND WALKING. If you patient's ability to stand and walk impaired?

   Yes. No. If yes, please specify:

   A. The maximum ability to stand and walk (with normal breaks) during an 8-hour day.

About 6hrs. about 4hrs about 3hrs about 2hrs. less than 2.

3. SITTING. Is your patient's ability to sit impaired?

   Yes. No. If yes, please specify:

A. The maximum ability to sit (with normal breaks) during an 8-hour day.

About 6hrs. about 4hrs about 3hrs about 2hrs. less than 2.

4. CHANGING POSITIONS. Does your patient have to periodically alternate sitting, standing or walking to relieve discomfort?

Yes. No. If yes, please specify:

How long your patient can **sit** before changing position?

0 5 10 15 20 30 45 60 90 minutes

How long your patient can **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.

5. NEED TO LIE DOWN. Will your patient sometimes need to lie down at unpredictable intervals during a work shift?

Yes. No.

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

6. POSTURAL LIMITATIONS. How often can your patient perform the following actions?

	Frequently	*Occasionally	**Never
Twist			
Stoop (bend)			
Crouch			
Climb stairs			
Climb ladders			
Kneel			
Crawl			
Balance			

*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

7. OTHER PHYSICAL FUNCTIONS. If your patient's ability to perform the following actions restricted?

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

8. ENVIRONMENTAL RESTRICIONS. Are your patient's symptoms affected by exposure to the following?

ENVIRONMENTAL RESTRICTIONS	**NO RESTRICTION**	**AVOID CONCENTRATED EXPOSURE**	**AVOID EVEN MODERATE EXPOSURE**	**AVOID ALL EXPOSURE**
Extreme cold				
Extreme heat				
Wetness				
Humidity				
Noise				
Fumes, odors, dusts, gases, poor ventilation, etc.				
Hazards (machinery, heights, etc.)				

9. OTHER IMPAIRMENTS. Does your patient exhibit signs of additional medical impairments?

Yes. No.

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10. MEDICAL FINDINGS. What medical findings, including the effects of pain and medication, support the preceding limitations?

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11. ABSENCE FROM WORK. 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 once a month ___ About three times a month

___Less than once a month ___About twice a month ___More than three times a month

12. ABILITY TO WORK FULL-TIME. In your professional opinion, is your patient capable of performing a full-time job, that is 8 hours per day, five days per week, on a regular and continuing basis?

Yes. No.

________________________________ ____________________________

Signature Date

Printed Name: ____

Address: ____

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Please return to:

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