Residual Functional Capacity Questionnaire
CHRONIC PANCREATITIS

Patient: _____

DOB: _____

Physician completing this form: _____

Please complete the following questions regarding this patient's impairments and attach all supporting treatment notes, radiologist reports, laboratory and test results.

Symptoms & Diagnosis

Does your patient exhibit chronic pancreatitis? ☐ Yes ☐ No

What other diagnoses has this patient received? _____

_____

Describe the patient's symptoms, such as pain, dizziness, fatigue, etc. _____

_____

_____

Does the patient have chronic pain/paresthesia? ☐ Yes ☐ No

Describe the patient's type of pain, location, frequency, precipitating factors, and severity. _____

_____

_____

Please indicate all positive objective signs exhibited by the patient:

☐ Abdominal pain, cramping and tenderness (Persistent) ☐ Bowel Incontinence
☐ Chronic Fatigue ☐ Diarrhea (Persistent) ☐ Dizziness (Recurrent) ☐ Fevers (Recurrent)
☐ Hot/Cold Spells ☐ Nausea/Vomiting ☐ Poor Appetite/Weight Loss
☐ Radiating Pain from Abdomen to Back ☐ Sleep Disturbance ☐ Urinary Frequency
☐ Weakness ☐ Other: _____

Does the patient exhibit bladder incontinence? ☐ Yes ☐ No
If yes, how often? _____ per week _____ per month

Does the patient exhibit bowel incontinence? ☐ Yes ☐ No
If yes, how often? _____ per week _____ per month

What is the earliest date that the above description of limitations applies? _____

Have these symptoms lasted (or are they expected to last) twelve months or longer? ☐ Yes ☐ No

Are this patient's symptoms and functional limitations impacted by emotional factors? ☐ Yes ☐ No
If yes, please mark any known psychological conditions that affect this patient's pain:
☐ Depression ☐ Anxiety ☐ Somatoform disorder ☐ Personality disorder
☐ Other: _____

Are these physical and emotional impairments reasonably consistent with the patient's symptoms and functional limitations? ☐ Yes ☐ No

If no, please explain: _____

_____

Testing & Treatments

Identify any positive clinical findings and test results, including ultrasound or ERCP. _____

_____

_____

Please list the patient's current medications: _____

_____

Please indicate the treatment type, start dates, and frequency: _____

_____

_____

What is the patient's prognosis? _____

Is this patient a malingerer? ☐ Yes ☐ No

Functional Work Limitations

When answering the following questions, please consider this patient's impairments and estimate his or her ability to work in a competitive work environment for an 8-hour shift with normal breaks.

How often do you expect this patient's pain or symptoms to interfere with the attention and concentration necessary to perform simple work tasks?

- ☐ Never
- ☐ Rarely (1% to 5% of an 8 hour working day)
- ☐ Occasionally (6% to 33% of an 8 hour working day)
- ☐ Frequently (34% to 66% of an 8 hour working day)
- ☐ Constantly

Mark the aspects of workplace stress that the patient most likely would unable to perform.

- ☐ Close interaction with co-workers/supervisors
- ☐ Detailed or complicated tasks
- ☐ Exposure to work hazards such as heights or machinery
- ☐ Fast-paced tasks, such as assembly lines
- ☐ Public contact
- ☐ Routine, repetitive tasks at consistent pace
- ☐ Strict deadlines
- ☐ Other: _____

_____

Is this patient taking any medications with side effects that may affect his or her ability to work?

- ☐ Yes ☐ No

If yes, please list possible side effects. _____

How far can the patient walk without rest or severe pain? _____

How long can this patient sit comfortably at one time before needing to get up?

Minutes: 0 5 10 15 20 30 45

Hours: 1 2 Longer than 2

What must the patient usually do after sitting this long?

☐ Stand ☐ Walk ☐ Lie Down ☐ Other: _____

How long can this patient stand comfortably at one time before needing to sit or walk around?

Minutes: 0 5 10 15 20 30 45

Hours: 1 2 Longer than 2

What must the patient usually do after sitting this long?

☐ Sit ☐ Walk ☐ Lie Down ☐ Other: _____

How long can this patient sit in an 8-hour working day?

- ☐ less than 2 hours
- ☐ about 2 hours
- ☐ about 4 hours
- ☐ at least 6 hours

How long can this patient stand and/or walk in an 8-hour working day?

- ☐ less than 2 hours
- ☐ about 2 hours
- ☐ about 4 hours
- ☐ at least 6 hours

Does the patient require a job with ready access to a bathroom? ☐Yes ☐No

Might the patient's symptoms likely cause unscheduled bathroom breaks? ☐ Yes ☐ No

If yes, how often? 1 2 3 4 5 6 7 8 9 10 >10 times

Might the patient require additional unscheduled breaks to lie down, change soiled clothing, or rest at unpredictable times? ☐ Yes ☐ No

If yes, how many times? 1 2 3 4 5 6 7 8 9 10 >10

For how many minutes? <5 5 10 20 30 45 60 90 >90

For which symptoms?

☐ Chronic fatigue ☐ Medication side effects ☐ Nausea/vomiting

☐ Pain/paresthesia ☐ Urinary frequency/incontinence ☐ Weakness

☐ other: _____

How many pounds can this patient lift and carry?

	Never	Rarely	Occasionally	Frequently
Less than 10 lbs.	☐	☐	☐	☐
10 lbs.	☐	☐	☐	☐
20 lbs.	☐	☐	☐	☐
50 lbs.	☐	☐	☐	☐

Are this patient's impairments likely to produce "good days" and "bad days"?

☐ Yes ☐ No

If yes, please estimate, on average, how many days per month your patient is likely to be absent from work as a result of the impairments or treatment:

☐ Never ☐ About three days per month

☐ About one day per month ☐ About four days per month

☐ About two days per month ☐ More than four days per month

Does this patient currently abuse alcohol or street drugs? ☐ Yes ☐ No ☐ Unsure

If yes, do you think the patient's described symptoms and limitations would diminish if sobriety was maintained? ☐ Yes ☐ No

Explain: _____

_____

If no, to the best of your knowledge, when was the last time your patient abused alcohol or street drugs? ☐ Never ☐ _____

Please describe any other limitations that might affect this patient's ability to work at a regular job on a sustained basis, such as psychological issues, limited vision or hearing, or the inability to adjust to temperature, wetness, humidity, noise, dust, fumes, gases or hazards, etc.

_____

_____

_____

Please describe additional tests or clinical findings not described on this form that clarify the severity of the patient's impairments.

_____

_____

_____

Completed by:

_____ _____

Physican's Printed Name Physician's Signature

_____ _____

Address Date

_____

_____