Residual Functional Capacity Questionnaire
CIRROSIS OF THE LIVER

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 cirrhosis? ☐ Yes ☐ No
If yes, what type? ☐ micronodular ☐ macronodular ☐ mixed

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/Tenderness (Recurring)		☐ Abdominal pain radiating to the back
☐ Anemia	☐ Ascites Asteixis	☐ Bowel Incontinence
☐ Cholangitis	☐ Chronic Fatigue	☐ Diarrhea (persistent)
☐ Dizziness (recurrent)	☐ Dysarthria	☐ Ecchymoticlesions
☐ Encephalopathy (with day/night reversal)		☐ Fevers (recurrent)
☐ Hematemesis	☐ Hepatitis ☐A ☐B ☐C	☐ Hepatocellura Insult
☐ Hot/Cold Spells	☐ Jaundice	☐ Nausea/Vomiting (recurrent)
☐ Peripheral Edema	☐ Poor Appetite/Weight Loss	☐ Sleep Disturbance
☐ Spontaneous Bacterial Peritonitis		☐ Pleural Effusions
☐ Spider Nevi	☐ Splenomegaly	☐ Tremor
☐ Urinary Frequency	☐ Urinary Incontinence	☐ Varices History
☐ Vomiting	☐ Weakness	☐ Other: _____

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: _____

_____

Medical Symptoms & Diagnoses

Identify any positive clinical findings and test results, including lab abnormalities, biopsy, ultrasound, barium studies, MRI, CT, etc. _____

_____

_____

Mark all of the following impairment this patient exhibits.

- ☐ Chronic liver disease
- ☐ Documented esophageal varices with massive hemorrhage due to these varices
- ☐ Shunt placed for esophageal varices
- ☐ Serum bilirubin of 2.5 mg or greater per deciliter (100ml) on repeated examinations for >5 months
- ☐ Ascites, not attributed to other causes, recurrent or persisting for at least 5 months, demonstrated by abdominal paracentesis or associated with persistent hypoalbuminemia of 3.0 gm. per deciliter or less
- ☐ Hepatic encephalopathy
- ☐ Confirmation of chronic liver disease by liver biopsy) and <u>one</u> of the following:
  - ☐ Ascites not attributable to other causes, recurrent or persisting for at least 3 months, demonstrated by abdominal paracentesis or associated with persistent hypoalbuminemia of 3.0 gr. Per deciliter (100ml.) or less; or
  - ☐ Serum bilirubin of 2.5 mg. per deciliter (100 ml) or greater on repeated examinations for at least 3 months; or
  - ☐ Hepatic cell necrosis or inflammation, persisting for at least 3 months, documented by repeated abnormalities of prothrombin time and enzymes indicative of hepatic dysfunction.

Identify any positive clinical findings that demonstrate these findings. _____

_____

_____

If the patient does not exhibit any of the above impairments, are the patient's combined impairments considered to be as medically severe as any one of listed impairments? ☐ Yes ☐ No

If yes, please explain. _____

_____

Identify any positive clinical findings and test results: _____

_____

_____

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

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
- ☐ 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 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

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

_____

_____