Residual Functional Capacity Questionnaire
SLEEP DISORDER

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

What 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:

☐ Atrial flutter	☐ Automatic behavior	☐ Cataplexy
☐ Cognitive problems	☐ Excessive daytime sleepiness	☐ Extreme bradycardia
☐ Hypercapnia	☐ Hypnogogic phenomenon	☐ Hypoxia
☐ Insomnia	☐ Obesity	☐ Pulmonary insufficiency
☐ Sleep paralysis	☐ Sinus arrhythmia	☐ Ventricular tachycardia

☐ Other: _____

Does the patient exhibit sleep apnea? ☐ Yes ☐ No

If yes, please mark the type: ☐ Obstructive ☐ Central ☐ Mixed

Does the patient exhibit recurrent daytime sleep attacks? ☐ Yes ☐ No If yes:

Can these attacks occur suddenly and in hazardous conditions (e.g., driving, while exposed to heights or moving machinery)? ☐ Yes ☐ No

How often do these attacks typically occur? _____ per day or _____ per week or _____ per month

For how long does your patient typically sleep with each attack? _____ minutes _____ hours

Identify situations that can precipitate attacks:

☐ Exertion	☐ Medication Side Effects	☐ Quiet
☐ Repetitive activity	☐ Sleep disturbance	☐ Other:_____

If your patient was working and has a sleep attack, would the attack likely disrupt the work of coworkers or supervisors in your patient's vicinity? ☐ Yes ☐ No

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

Testing & Treatments

Identify any positive clinical findings and test results, including multiple sleep latency test, MSLT, MWT, REM testing, EEG, polysomnographic studies, etc.:_____

_____

_____

Please list the patient's current medications:_____

_____

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

_____

_____

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: _____

_____

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

How well do you expect this patient to be able to tolerate work stress?

- ☐ Incapable of even "low stress" jobs
- ☐ Only capable of low stress jobs
- ☐ Moderate stress is okay
- ☐ Capable of high stress situations

Explain: _____

_____

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 this 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 this patient require unscheduled breaks?

☐ Yes ☐ No

If yes, how often? _____

For how long? _____ minutes

For which symptoms?

☐ Chronic Fatigue ☐ Daytime Sleep Attacks ☐ Medication side effects

☐ 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

Do the patient's impairments require limited exposure to changes in the environment?

	No Exposure Restriction	Avoid Prolonged Exposure	Avoid Moderate Exposure	Avoid All Exposure
Driving	☐	☐	☐	☐
Heights	☐	☐	☐	☐
Moving dangerous machinery	☐	☐	☐	☐
Power Tools	☐	☐	☐	☐
Routine, repetitive tasks	☐	☐	☐	☐
Working without supervision	☐	☐	☐	☐
Others: _____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐

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

_____

_____