# Residual Functional Capacity Questionnaire
# SICKLE CELL ANEMIA

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 have sickle cell anemia? ☐ 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:

| | | |
|---|---|---|
| ☐ Acute joint pain | ☐ Aplastic crises | ☐ Cardiac abnormalities |
| ☐ Chronic fatigue | ☐ Hemolytic crises | ☐ Jaundice |
| ☐ Liver abnormalities | ☐ Poorly healing leg ulcers | ☐ Retinopathy |
| ☐ Spenomegaly | ☐ Other: _____ | ☐ Other: _____ |

Please mark the situations your patient exhibits related to sickle cell disease:
☐ Documented painful (thrombotic) crises occurring at least three times during the past five months
☐ Documented painful (thrombotic) crises requiring extended hospitalization at least three times during the past 12 months
☐ Chronic, severe anemia with persistence of hematocrit of 26 % or less

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 hematocrit:_____

_____

_____

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

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 ☐ Medication side effects ☐ Muscle weakness

☐ Pain/paresthesia ☐ Other: _____

During occasional standing/walking, does this patient require a cane or other assistive device?

☐ Yes ☐ No

For which symptoms?

☐ Claudication ☐ Pain/paresthesia ☐ Other: _____

How many pounds can this patient lift and carry?

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

Does this patient have significant limitations with repetitive reaching, handling or fingering?

☐ Yes ☐ No

If yes, please indicate the percentage of time this patient can perform the following activities:

Using hands to grasp, turn and twist objects Right _____% Left _____%

Using fingers for fine manipulation Right _____% Left _____%

Using arms to reach out and overhead Right _____% Left _____%

For which symptoms?

- ☐ Pain/paresthesia
- ☐ Swelling
- ☐ Medication side effects
- ☐ Motor Limitation
- ☐ Motor loss
- ☐ Muscle weakness
- ☐ Sensory loss
- ☐ Other: _____

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

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

_____

_____