Residual Functional Capacity Questionnaire
SYSTEMIC LUPUS ERYTHEMATOSUS

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 fulfill the diagnostic criteria for systemic lupus erythematosus, as defined by the American College of Rheumatology? □ Yes □ No

Please mark all positive indicators:

- □ Malar rash on cheeks
- □ Discoid rash
- □ Photosensitivity
- □ Oral Ulcers
- □ Non-erosive arthritis involving pain in two or more peripheral joints.
  - If yes, do affected joints also exhibit persistent swelling, redness, significant limitation of motion, tenderness or warmth? ____________________________
  - Indicate affected joints: ________________________________________________
- □ Cardiopulmonary involvement shown by pleurisy or low pericarditis.
- □ Renal involvement shown by persistent proteinuria
  - □ greater than 0.5 gm/day □ 3+ on test sticks □ cellular casts
- □ Central nervous system involvement shown by seizures and/or psychosis (in absence of drugs or metabolic disturbances known to cause such effect
- □ Hemolytic anemia or leukopenia (WBC below 4,000/mm$^3$) or lymphopenia (below 1,500 lymphocytes/mm$^3$) or thrombocytopenia (below 100,000 platelets/mm$^3$)
- □ Positive LE cell preparation or anti-DNA or anti-Sm anti-body or false positive serum test for syphilis known to be positive for at least six months
- □ Positive test for ANA at any point in time (in absence of drugs known to cause abnormality)

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 Cramping/Pain
- Avascular Necrosis
- Bruising easily
- Changed Clotting Capacity
- Constipation
- Dermal Vasculitis
- Diarrhea
- Fatigue (severe)
- Fever (severe)
- Frequent Infections (including UTI)
- Hair Loss
- Impaired Coordination
- Lymph Node Enlargement
- Lupoid Hepatomegaly
- Malaise (severe)
- Migraine Headaches
- Muscle Weakness
- Nausea/Vomiting
- Paralysis Episodes (central nervous system involvement)
- Raynaud's Phenomenon
- Peripheral Neuropathy
- Peritonitis
- Sjogren's Syndrome
- Sleep Issues
- Urinary Urgency
- Urinary Incontinence
- Vision Impairments
- Weight Loss (severe)
- Other: ____________________________

Does the patient complain of gastrointestinal issues? □ Yes □ No
- If yes, what is the severity? □ Mild □ Moderate □ Severe

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 renal/cardiopulmonary involvement: __________

________________________________________________________________________

________________________________________________________________________

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 malingering? □ 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: ________________________________________________________________

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 need to include periods of walking in an 8-hour working day?
- □ Yes   □ No
  If yes, how often?  5  10  15  20  30  45  60  90 minutes
  For how many minutes?  1  2  3  4  5  6  7  8  9  10  11  12  13  14  15
Does this patient require a job that allows the opportunity to change between sitting, standing and walking at will?  □ Yes  □ No

Does this patient require unscheduled breaks?
□ Yes  □ No
If yes, how often?
During this time, this patient will need to  □ lie down  □ sit quietly for ________________ minutes.

With prolonged sitting, should this patient’s leg(s) be elevated?
□ Yes  □ No
If yes, for what percentage of time in an 8-hour day? _______%

During occasional standing/walking, does this patient require a cane or other assistive device?
□ Yes  □ No

How many pounds can this patient lift and carry?

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 10 lbs.</td>
<td>□</td>
<td>□</td>
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<tr>
<td>10 lbs.</td>
<td>□</td>
<td>□</td>
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<tr>
<td>20 lbs.</td>
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<td>□</td>
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<tr>
<td>50 lbs.</td>
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</tbody>
</table>

How often can your patient perform the following activities?

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Frequently</th>
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</thead>
<tbody>
<tr>
<td>Twist</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Stoop (bend)</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Crouch</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Climb ladders</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Climb stairs</td>
<td>□</td>
<td>□</td>
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</tbody>
</table>

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 _______%

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

<table>
<thead>
<tr>
<th></th>
<th>No Exposure Restriction</th>
<th>Avoid Prolonged Exposure</th>
<th>Avoid Moderate Exposure</th>
<th>Avoid All Exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemicals</td>
<td>□</td>
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<td>□</td>
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<tr>
<td>Extreme Cold</td>
<td>□</td>
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<td>□</td>
<td>□</td>
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<tr>
<td>Extreme Heat</td>
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<tr>
<td>High Humidity</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Fumes, odors, dusts, gasses</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Perfumes</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Cigarette Smoke</td>
<td>□</td>
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<tr>
<td>Soldering Fluxes</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Solvents/Cleaners</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Others: __________________________</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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</tbody>
</table>

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
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:

____________________________________________________________________________________

Physician’s Printed Name  Physician’s Signature

____________________________________________________________________________________

Address  Date