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? ________________________________ minutes

For which symptoms?

- Chronic Fatigue
- Daytime Sleep Attacks
- Medication side effects
- Other: ________________________________________________________________
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>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>10 lbs.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>20 lbs.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>50 lbs.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</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

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

- 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:

__________________________  __________________________
Physician’s Printed Name  Physician’s Signature

__________________________  __________________________
Address  Date