Residual Functional Capacity Form/Medical Opinion Statement

Patient Name: *Hank Gonzalez* **Date of Birth:** *09/09/1974*
Social Security #: *999-00-1111*

Please respond to the following questions regarding your patient's ability to perform work-related physical activities. When answering the questions, please be specific with regards to what evidence in your patient's records supports your opinion. This will be used as medical evidence for a Social Security disability claim or a private long-term disability claim.

Section A: Medical History

1. When did you begin treating the patient?

    I first saw Mr. Gonzalez on October 30, 2021.

2. How often do you see the patient?

    I've seen Mr. Gonzalez every month for the past two-and-a-half years.

3. What is your diagnosis of the patient's medical impairment(s)?

    Severe carpal tunnel syndrome in his right hand and rotator cuff tear in the right shoulder.

4. What is your prognosis for the patient (good, fair, poor)?

    Fair to poor.

5. Please list the medical findings that you use to support your diagnosis:

    A nerve conduction study on May 12, 2022 showed significant latency in his right medial and ulnar nerves. An MRI conducted a few days later on May 15 showed an almost complete rotator cuff tear in his right shoulder.

6. Please describe any treatment the patient has completed so far and the results of the treatment:

    Mr. Gonzalez began conservative treatment with hand splints and corticosteroid injections after the results of the nerve conduction study came back. He had several injections over the course of six months which did not relieve his symptoms. Mr. Gonzalez underwent a carpal tunnel release on December 29, 2022, but his hand still

trembled when grasping utensils or pressing buttons. Shoulder surgery was scheduled on August 3, 2023, but his symptoms did not improve. Physical therapy intended to increase his range of motion in his right shoulder was somewhat successful, but he was still limited in moving his right arm above his head and away from his torso.

Section B: Signs and Symptoms

7. Please identify the medical signs, present on physical examination, of your patient's impairment(s):

Mr. Gonzalez has positive Tinel's sign and positive Phalen's maneuver, two common indicators of carpal tunnel syndrome. He has reduced range of motion in his upper right shoulder.

8. Please identify the symptoms of your patient's impairment(s):

Mr. Gonzalez has difficulty moving his right (dominant) hand. He has trouble making a fist or pressing buttons such as laptop keys. Cramping and stiffness in his hands causes him to drop small objects like pens. Repetitive motions increase numbness and pain in his fingers. Due to his rotator cuff tear in his right shoulder, he can't lift more than a gallon of milk without a shooting pain down his arm.

Section C: Functional Limitations

9. Does your patient have limitations in their ability to stand? ___ Yes __✓__No

If yes, please circle the number that best describes the total amount your patient can stand in an 8-hour workday:

Less than 2 hours 2 hours 4 hours 6 hours

What is the longest your patient can stand at one time before they need to sit down (in minutes or hours)?

Mr. Gonzalez' ability to stand isn't affected by his carpal tunnel syndrome or rotator cuff tear.

10. Does your patient have limitations in their ability to walk? _____ Yes __✓___No

If yes, please circle the number that best describes the total amount your patient can walk in an 8-hour workday:

Less than 2 hours 2 hours 4 hours 6 hours

What is the longest your patient can walk at one time before they need to sit down (in minutes, hours, or distance)?

Mr. Gonzalez' ability to walk isn't affected by his carpal tunnel syndrome or rotator cuff tear.

Does your patient require an ambulatory aid, such as a walker or cane?

____ Yes __✓___No

12. Does your patient have limitations in their ability to sit? ____ Yes __✓___No

If yes, please circle the number that best describes the total amount your patient can sit in an 8-hour workday:

Less than 2 hours 2 hours 4 hours 6 hours

What is the longest your patient can sit at one time before they need to get up (in minutes or hours)?

Mr. Gonzalez' ability to sit isn't impacted by his carpal tunnel syndrome or rotator cuff tear.

13. Does your patient have limitations on lifting and carrying? __✓__ Yes _____No

If yes, please circle the number that best describes the heaviest amount, in pounds, that your patient can *occasionally* (up to 1/3 of the workday) lift or carry:

Less than 10# (10#) 20# 50# 100#

Please circle the number that best describes the heaviest amount, in pounds, that your patient can *frequently* (up to 2/3 of the workday) lift or carry:

(Less than 10#) 10# 20# 50# 100#

14. Does your patient need to be able to change positions at will? __✓_ Yes _____No

If yes, how often do you think your patient will need to shift positions during the workday?

While Mr. Gonzalez doesn't need to shift between sitting, standing, and walking, he would benefit from doing 10 minute stretching exercises with his arms, hands, and fingers every 30 minutes.

15. Does your patient need to be able to lie down during the day? ____ Yes __✓__No

    If yes, how often do you think your patient will need to lie down during the day and for how long?

16. Does your patient need to be able to elevate their legs? ____ Yes __✓___No

    If yes, how long does your patient need to elevate their legs for and at what height (e.g., at waist level)?

17. Please check the box that best describes how often your patient can perform the following actions in an 8-hour workday:

	Rarely or Never (very little, if at all)	Occasionally (up to 1/3 of the day)	Frequently (1/3-2/3 of the day)
Twist	____	____	__X_
Bend	____	____	__X_
Crouch	____	____	__X_
Climb stairs	____	____	__X_
Climb ladders	__X_	____	____
Kneel	____	____	__X_
Crawl	____	____	__X_
Balance	____	____	__X_

Ladders should be avoided as Mr. Gonzalez does not have the grip strength to safely climb one

18. Does your patient have limitations in the upper extremities? __✓___ Yes _____No

    If yes, please check the box that best describes how often your patient can use their arms, hands, and fingers to perform the following activities:

	Rarely or Never (very little, if at all)	Occasionally (up to 1/3 of the day)	Frequently (1/3-2/3 of the day)
Reaching overhead	_X__	____	____
Reaching laterally	_X__	____	____
Handling	___	_X__	____

Fingering	___	_X__	____
Feeling	___	_X__	____
Grasping	___	_X__	____

19. Are your patient's symptoms exacerbated by exposure to certain environmental conditions? ____ Yes __✓___No

If yes, please check the box that best describes how often your patient should come into contact with the following factors:

	Avoid All Exposure	Avoid Concentrated Exposure	Avoid Moderate Exposure	No Restrictions
Extreme cold	___	___	___	_X__
Extreme heat	___	___	___	_X__
Wetness	___	___	___	_X__
Humidity	___	___	___	_X__
Noise	___	___	___	_X__
Fumes or gases	___	___	___	_X__
Hazards	___	___	___	_X__
Heights	___	___	___	__X_

20. Does your patient experience pain? __ ✓ ___ Yes _____No

If yes, please describe the location, intensity, and frequency of the pain:

Daily stabbing pain in the shoulders, radiating down into the arm and wrist. Shocking pain in the fingers and knuckles, depending on the day.

21. Do your patient's symptoms affect the ability to concentrate or maintain attention? __ ✓___ Yes _____No

If yes, please circle the percentage of the workday that best represents how often these symptoms are severe enough to interfere with tasks:

5% 10% (15%) 20% 25% Over 25%

22. Do your patient's symptoms result in "good days" and "bad days"? __✓__ Yes ____No

The intensity of the pain varies depending on how much activity Mr. Gonzalez engaged in the previous day. If he hasn't gotten dressed, taken a shower, or cleaned the dishes, his arms and hands can be as low as a 2 or a 3 (out of 10),

but because he does these tasks at least every other day, he'll have pain at a 6 or 7 several times a week.

23. Would your patient's symptoms or treatment result in absences from work?
__✓__ Yes _____No

If yes, please circle the amount that best represents how often your patient would miss work per month:

Less than one day (One day) Two days Three days More than three days

Section D: Professional Observations

24. Has your patient cooperated with your treatment recommendations?
__✓__ Yes _____No

If not, please explain why your patient was unable to follow the recommended treatment: _____

25. Does your patient have a history of drug or alcohol abuse? _____ Yes __✓___No

If yes, would your patient's symptoms exist or persist despite drug or alcohol use?
_____ Yes _____No

26. Does your patient exaggerate symptoms? _____ Yes __✓____No

27. Do you expect the patient's limitations to last at least one year? __✓__ Yes _____No

28. On what date did these limitations begin?

These limitations existed at least as early as October 30, 2021, when I first examined Mr. Gonzalez.

29. In your opinion, are your patient's limitations reasonably consistent with the objective medical evidence and physical evaluations as a whole? ___✓__ Yes _____No

Doctor's Name and Signature: *Ivy Ingraham, M.D* **Date:** *2/21/2024*

Ivy Ingraham, M.D.

Doctor's Address: *860 Kula Lane, Lahaina, HI 96112*