Residual Functional Capacity Form/Medical Opinion Statement

Patient Name: *Odell Collins* **Date of Birth:** *05/05/1968*
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. Collins on February 13, 2016.

2. How often do you see the patient?

    Typically 3-4 times a year.

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

    Congestive heart failure.

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

    Prognosis for Mr. Collins is fair to poor. He has been relatively stable with progressively more invasive treatment, but his health has been deteriorating with age, and it's likely that he will require additional surgery in the future.

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

    Mr. Collins underwent several electrocardiograms (EKGs) over a span of several years showing that his left ventricular wall had thickened and his left atrial wall was enlarged, resulting in a greatly decreased ejection fraction.

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

    I put Mr. Collins on a medication regimen to help lower his blood pressure, but his symptoms persisted. Mr. Collins had an angioplasty to place a stent in his arteries which increased his tolerance for exertion somewhat, but over time his symptoms returned. I

then suggested that Mr. Collins have a pacemaker implanted in 2023, which has been successful so far. However, Mr. Collins continues to complain of getting tired easily.

Section B: Signs and Symptoms

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

Mr. Collins' EKGs and stress tests reveal that he has an extremely low tolerance for physical exertion.

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

Mr. Collins experiences fatigue, shortness of breath, and chest pain after even minimal exertion. He struggles with basic physical activities such as walking on a slight incline or climbing stairs.

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)?

As long as he isn't moving or lifting, Mr. Collins can stand for about 30-45 minutes before he needs to sit down.

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. Collins' symptoms worsen significantly when he is walking. He can walk for about 5 to 10 minutes without stopping. However, he can only do this at a slow pace on a flat and dry surface. After walking, Mr. Collins needs to sit down for 10-15 minutes to catch his breath before he can resume walking.

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. Collins can sit for six hours out of an eight hour day if he is avoiding other strenuous activities.

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?

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?

Several times a week, Mr. Collins experiences overwhelming fatigue that can come on suddenly and without warning. He needs the ability to lay down for about 30 minutes to one hour when these events occur.

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_	____

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:

Sharp, squeezing pain in the chest, about once or twice a week. Mr. Collins describes the pain as "excruciating" but temporary, and remedied with his medications. He mentions feeling "totally out of it" for an entire day afterwards, however.

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

The side effects of Mr. Collins' medications can cause headaches, dizziness, and gastrointestinal issues that may require him to take extra breaks.

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. Collins has 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 have existed since 2016.

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: *Becky Leland, M.D* **Date:** *2/21/2024*

Becky Leland, M.D.

Doctor's Address: *9 Clearview Blvd., Tappany, CT, 18360*