Washington State Department of Social & Health Services

Transforming lives

Physical Functional Evaluation

1. Payment for a general or comprehensive physical evaluation is contingent upon receipt of available chart notes from within the past six months, as well as supporting evidence including lab results, pathology reports, diagnostic imaging reports, and range of motion studies. You must be enrolled in ProviderOne to claim reimbursements for these services.
2. As you examine this patient, please evaluate all medical conditions that may limit their ability to work. You are not limited to evaluating the presenting condition(s). **You are not required to complete any special test of functional capacity to render your professional medical opinion on this form.**

   Confidentiality: The information you provide is subject to Washington State Public Disclosure laws and may be released to the client upon request. DSHS discloses no further information without the written consent of the individual to whom it pertains or as otherwise permitted by state law.

A. Client Information

NAME	BIRTH DATE	CLIENT IDENTIFICATION NUMBER

B. Authorization to Release Information

I authorize _____ to release the following information to the Department of
EXAMINING PROFESSIONAL'S NAME

Social and Health Services (DSHS). This release includes the contents of this evaluation as well as diagnostic testing or treatment information concerning mental health, alcohol or drug use , sickle cell disease, and sexually transmitted disease, including HIV/AIDS (Chapter 70.02 Revised Code of Washington (RCW) (42 Code of Federal Regulations (CFR) Part 2).

This authorization is valid for one year or until _____ (date).

I may revoke or withdraw this authorization in writing at any time.

I understand that the information provided to DSHS may be re-disclosed only with a valid authorization from me or if required by law.

CLIENT'S SIGNATURE	DATE

C. Subjective

Chief complaints and reported symptoms:

Barcode label

14001

Reported onset of primary impairment: _____ (date).

Describe any treatment history including hospitalizations:

D. Objective

Attach chart notes detailing examination findings.

Describe any non-exertional limitations or workplace restrictions (such as chemical sensitivities or inability to work at heights):

List all laboratory, imaging, range of motion, and other diagnostic test results (attach reports):

E. Assessment

1. List each diagnosis in Column 1 below, starting with the primary impairment.
2. In Column 3 below, estimate the severity of the diagnosis based on your professional medical opinion using the following definitions:

RATING	SEVERITY	DEFINITION
1	None	No interference with the ability to perform one or more basic work-related activities
2	Mild	No significant interference with the ability to perform one or more basic work-related activities
3	Moderate	Significant interference with the ability to perform one or more basic work-related activities
4	Marked	Very significant interference with the ability to perform one or more basic work-related activities
5	Severe	Inability to perform one or more basic work-related activities

Basic work activities include (a) sitting, (b) standing, (c) walking, (d) lifting, (e) carrying, (f) handling, (g) pushing, (h) pulling, (i) reaching, (j) stooping, (k) crouching, (l) seeing, (m) hearing, and (n) communicating.

DIAGNOSIS	AFFECTED WORK ACTIVITY (See (a) – (n) above)	SEVERITY RATING

In your professional medical opinion, what work level is the client capable of performing in a regular* predictable manner despite their impairment?

☐ **Heavy work**.....Able to lift 100 pounds maximum and frequently** lift or carry up to 50 pounds.

☐ **Medium work**.....Able to lift 50 pounds maximum and frequently** lift and/or carry up to 25 pounds.

☐ **Light work**.....Able to lift 20 pounds maximum and frequently** lift or carry up to 10 pounds, able to walk or stand six out of eight hours per day, and able to sit and use pushing or pulling arm or leg movements most of the day.

☐ **Sedentary work** .Able to lift 10 pounds maximum and frequently** lift or carry lightweight articles. Able to walk or stand only for brief periods.

☐ **Severely limited**.Unable to meet the demands of sedentary work.

* Regular predictable manner means the person is capable of sustaining the work level over a normal workday and workweek on an ongoing, appropriate, and independent basis.

** Frequently means the person is able to perform the function for 2.5 to 6 hours out of an 8 hour day. It is not necessary that performance be continuous.

DURATION

How long do you estimate the current limitation on work activities will persist with available medical treatment? _____ MONTHS

SUBSTANCE ABUSE

Are the effects on basic work activities primarily the result of substance use disorder? ☐ Yes ☐ No

Please explain:

Would the effects on basic work activities persist following 60 days of sobriety? ☐ Yes ☐ No

If not, how would they change?

Is a chemical dependency assessment of substance use treatment recommended? ☐ Yes ☐ No

F. Plan

List any additional tests or consultations needed:

What treatment is recommended?

RETURN THIS REPORT TO:	PRINT NAME OF EXAMINING PROFESSIONAL	EXAMINATION DATE
	SPECIALTY AREA/ADVANCED TRAINING	TELEPHONE NUMBER
WORKER SIGNATURE DATE	STREET ADDRESS CITY STATE ZIP CODE	
TELEPHONE NUMBER	EXAMINING PROFESSIONAL'S SIGNATURE/TITLE DATE	
FAX NUMBER	REVIEWING AND ADOPTING PROFESSIONAL'S SIGNATURE DATE	