

PERFORMANCE-BASED PHYSICAL CAPACITIES EVALUATION

THE DEPT. OF LABOR & INDUSTRIES' FORMAT FOR PERFORMANCE EVALUATION REPORT BY OCCUPATIONAL OR PHYSICAL THERAPIST

Therapist: Please include the following information in your report. Use only the items that apply if the evaluation is for a specific question. Attach your report to the summary form enclosed. Send copies to: the attending physician, attorney, claims manager, and vocational counselor. The original report should be sent to the person making the referral.

SECTION I: CLIENT IDENTIFICATION

NAME: DATE OF BIRTH: AGE:
CLAIM #: MALE/FEMALE:
DATE OF INJURY: CURRENT DIAGNOSIS:

REFERRAL REASON:

BACKGROUND INFORMATION:

Rx, X-Rays, CT Scan, Myelogram, Surgery, Pain Clinics.

SECTION II: SUBJECTIVE COMPLAINTS

A subjective description by the client of results of the injury or illness. Areas of discomfort, description of discomfort, what affects the symptoms, level of discomfort, sleep pattern. You may use a body diagram to indicate areas and type of discomfort. You may use a pain scale. Please include an explanation if either is used.

Medication being used (include prescription and over-the-counter, street drugs, alcohol). How often?
Any assistive devices i.e., prostheses/braces, crutches, wheelchairs, ace wrap, TNS, etc.

SECTION III: SUBJECTIVE FUNCTIONAL LEVEL

The client's description of daily activity. Comment on activity or difficulty with:

Self care
Household chores
Yard work
Car maintenance/driving
Shopping
Recreation
Exercise/Rest periods

Does the client have an occupational goal in mind? Use client's own words.

SECTION IV: OBJECTIVE DATA

DEFINITIONS

The definitions below (1-5) are an adaptation from information gathered from Stover Snook's research on Manual Handling Tasks (1978). The percentages in parentheses can be used to estimate the amount of weight a client can handle in the various categories, given their maximum effort in a weight handling task. These definitions are intended to be used as guidelines.

1. Never - Use this designation if you feel that this client should NEVER attempt this particular activity.
2. Seldom - This designation is used to indicate one lift/activity per hour up to a MAXIMUM of eight lifts/activities in an 8 hour work day. (Maximum effort).
3. Occasional - This designation is used to indicate a MAXIMUM of one lift/activity per 3 minutes, 20 lifts/activities per hour, up to a MAXIMUM of 140 lifts/activities per 8 hour work day. (80% of max. effort).
4. Frequently - This designation is used to indicate one lift/activity per 1.5 minutes, 40 lifts/activities per hour, up to a MAXIMUM of 280 lifts/activities per 8 hour day. (70% of maximum effort).
5. Continuously - This designation is used to indicate one lift/activity per minute, 60 lifts/activities per hour, up to a maximum of 420 lifts/activities per 8 hour day. (50% of maximum effort).

DEFINITIONS - POSITIONS/MOTIONS

1. Bend/Stoop: The client assumes a posture of bending/stooping forward from waist, keeping the knees straight.
2. Crouch: The client assumes this posture with the upper body bent forward from the hips/waist and the knees bent to work at an activity below waist level.
3. Twist: An activity where the feet remain in position, and the upper body is rotated from a neutral position to the left or the right, most of the motion coming from the hips and above.

REPORT CONTENTS

Height
Weight (Amount of change since injury)
BP/Pulse
Balance
Posture
ROM - Any limitations that would decrease work function?
Gait - any abnormalities? Consistent throughout evaluation?

Activity Tested:

Strength Testing: (Describe method/Apparatus used)

Lifting - maximum - reason for stopping activity (objective data: not pain behavior)

Range of functional lifting activity, i.e.

from floor to 36", from floor to waist, from waist to shoulder, from shoulder to overhead

Endurance/frequency: amount of weight, # reps, clear task description

Carrying - 25' minimum. Reason for stopping activity

Stairs - Ascend/descend 1 flight; maximum of 5 repetitions (9-11 stairs) - reason for stopping activity

Sitting - 2 hours at a time maximum

Standing/Walking speed - 2.5 - 3.0 MPH normal (100' in 22 seconds = 3.0 MPH)

Reaching - Upward, forward, overhead

Kneeling

Squatting

Stooping/Crouching

Pushing - Pulling (describe method)

Crawling

If condition affects these items, further tests may include:

Cardiovascular/endurance

Hand grip/pinch strength

Isometric back/leg strength

Hand dexterity

Color discrimination

SECTION V: OTHER OBSERVATIONS

Vision screening

Communications skills - verbal/written

Cognitive abilities

Attitude and behavior

Body mechanics - proper/improper usage

Work behaviors

SECTION VI: CONCLUSIONS

Summarize the injured worker's abilities and complete the summary form. Comment on validity and/or consistency throughout the testing. Note what was observed.

PCE lasted _____ hours over _____ day(s)

SECTION VII: RECOMMENDATIONS

Level of work activity recommended using the Dictionary of Occupational Titles standards.

Part-time/Full-time

Limitations

Remedial programs that might reduce client's physical restrictions

THERAPISTS SUMMARY

PERFORMANCE - BASED PHYSICAL CAPACITIES EVALUATION

1. Date of Evaluation 2. Claim # 3. Client's Name 4. Referral Source
 _____/_____/_____ / _____/_____/_____

5. Accepted Condition(s):

The injured worker can:

6. Sit for _____ hours at a time; _____ hours in an 8 hour day.
 _____ hours without restriction.
 _____ hours intermittently throughout an 8 hour day (frequent changes of position).
7. Stand for _____ hours at a time; _____ hours in an 8 hour day.
 _____ hours without restriction.
 _____ hours intermittently throughout an 8 hour day (frequent changes of position).
8. Walk for _____ hours at a time; _____ hours in an 8 hour day.
 _____ hours without restriction.
 _____ hours intermittently throughout an 8 hour day (frequent changes of position).
9. Alternately sit/stand/walk for _____ hours at a time; _____ hours in an 8 hour day.
10. Lift _____ # occasionally from _____ height to _____ height e.g. floor to waist or knuckle.
 _____ # occasionally from _____ height to _____ height e.g. waist or knuckle to shoulder.
 _____ # occasionally from _____ height to _____ height e.g. shoulder to overhead.
- _____ # frequently from _____ height to _____ height e.g. floor to waist or knuckle.
 _____ # frequently from _____ height to _____ height e.g. waist or knuckle to shoulder.
 _____ # frequently from _____ height to _____ height e.g. shoulder to overhead.
11. Carry _____ # occasionally for _____ (distance)
 _____ # frequently for _____ (distance)
12. Push with _____ # of force occasionally; _____ # of force frequently.
 Pull with _____ # of force occasionally; _____ # of force frequently.
13. N = Never _____ Squat _____ Reach overhead with weight _____ #
 S = Seldom _____ Kneel _____ Perform fine manipulation
 O = Occasionally _____ Bend/Stoop _____ Operate foot controls
 F = Frequently _____ Crouch _____ Operate hand controls
 C = Continuously _____ Climb: stairs
 WNL = Within normal limits _____ ladder

14. COMMENTS:

15. Evaluator's Signature _____ date ____/____/____
 Name of evaluator's firm _____

16. This information was gathered during a _____ hour Physical Capacities Evaluation over _____ day(s).

17. TO ATTENDING DOCTOR:

If you have concerns or comments regarding the findings of this performance-based PCE, please return this summary with attached comments to:

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Date(s) that the PBPCE was administered.
2. Client's claim number, with unit designation, if you have this available.
3. Client's last name, first name and middle initial.
4. Identify the source of the referral by name and profession, i.e., physician, VRC., Chiropractor, claims manager.
5. Accepted condition. This should be on the request for services form, or available from a VRC contact.
6. The duration client can sit comfortably at any one time; and the duration a client can sit in an 8-hour day.
Duration client can sit without restrictions.
Duration client can sit intermittently throughout an 8-hour day.
7. Duration client can stand comfortably at any one time, and the duration a client can stand comfortably in an 8-hour day.
Duration client can stand without restriction.
Duration client can stand intermittently throughout an 8-hour day.
8. Duration client can walk at a time and walk in an 8-hour day.
Duration client can walk without restrictions.
Duration client can walk intermittently throughout an 8-hour day.
9. Duration client can alternately sit/stand/walk at a time, and in an 8-hour day.
10. Weight client can lift occasionally.
Weight client can lift frequently.
11. Weight client can occasionally carry. State distance used for evaluation.
Weight client can frequently carry using the evaluation distance.
12. Force client can occasionally exert for pushing activities; force client can exert on a frequent basis.
Force client can occasionally exert for pulling activities; force client can exert on a frequent basis.
13. Indicate how frequently client can perform these activities: N = never; S = seldom; O = occasionally; F = frequently; C = continuously; WNL = within normal limits. See definitions.
14. Comments: Significant observations, examples: "Client's eye/hand coordination performance was good." "Given the above information, client is unable to function for more than 6 hours at a sedentary level of activity." "Client demonstrated frequent pain behavior."
15. A licensed Physical or Occupational Therapist's signature is required.
16. How many hours did it take to administer the PCE, including breaks and lunch time? How many days? Do not include preparation time or report writing time.
17. Type the licensed therapist's name, the business name, and address in the space provided at the bottom of this form, so the Doctor can send comments and concerns to you.