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| http://inside.lni.wa.gov/Director/resources/GraphicIdentity/BlackPrint.pngClaimsPO Box 44291Olympia WA 98504-4291 | **Capacity Summary** |

|  |  |
| --- | --- |
| [ ]  Work Rehabilitation Program | [ ]  Functional Capacity Evaluation (FCE) |

|  |  |  |  |
| --- | --- | --- | --- |
| Worker Name:      | Date of Report:enter a date. | Date of Injury:enter a date. | Claim Number:      |
| Accepted Conditions:      |

|  |  |
| --- | --- |
| Clinic Name:      | Clinic Phone Number:      |
| Clinic Address:      | City:      | State:      | Zip Code:      |
| Vocational Provider Name:      | Attending/Referring Provider Name:      |

|  |  |
| --- | --- |
| Start Date of ServiceClick or tap to enter a date. | End Date of ServiceClick or tap to enter a date. |
| Total Number of visits      | Number of No Shows      | Number of Cancellations      | **Stand-alone FCE Only**: Hours of Direct Time      |

**Performance Validity:**

|  |
| --- |
| [ ]  Yes [ ]  No Were you able to make return-to-work conclusions based on the worker’s performance and reliability measurements? **If No**, do not complete the Responses to Job Analysis and Capacity Grid sections. |
| Explain how you reached or were unable to reach, your conclusions.      |

**Responses to Job Analysis/Job Description:**

|  |  |  |
| --- | --- | --- |
| Job Title/Job of Injury/Goal | Can perform this job goal? | **If No**, what task(s) are limited? Describe how tasks are limited based on what objective claim related factors. |
| 1. |       | [ ]  Yes [ ]  No |       |
| 2. |       | [ ]  Yes [ ]  No |       |
| 3. |       | [ ]  Yes [ ]  No |       |
| 4. |       | [ ]  Yes [ ]  No |       |
| 5. |       | [ ]  Yes [ ]  No |       |

|  |  |
| --- | --- |
| Worker Name:test | Claim Number:  |

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| --- |
| **Unrelated Conditions/Factors:** Describe any unrelated condition/factors and how they affected specific job goals or tasks.      |
| Attending Provider Restrictions to Service [ ]  None/Test to Tolerance [ ]  Other (Lifting, Cardiac)      |
|  |
| **Other referral questions:** List and answer any additional questions asked by the claim manager, vocational provider, employer, and/or attending provider.      |
| **Additional observations/comments:**      |

**Capacity Grid**

|  |  |  |
| --- | --- | --- |
| Projected Work Tolerance:  |      \_Hours Per day | \_\_      Total Hours per week |
| Sit for |       [ ]  Minutes [ ]  Hours at a time |       Hours per day |
| Stand for |       [ ]  Minutes [ ]  Hours at a time |       Hours per day |
| Walk for |       [ ]  Minutes [ ]  Hours at a time |       Hours per day |
| Alternately sit/stand/walk for |       [ ]  Minutes [ ]  Hours at a time |       Hours per day |
| Alternately stand/walk for |       [ ]  Minutes [ ]  Hours at a time |       Hours per day |
| For combined activities of sit/stand/walk or stand/walk, 2 hours in an 8-hour day is considered within normal limits. |
| **Comments:** |

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| --- | --- |
| Worker Name:test | Claim Number:  |

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| --- | --- | --- | --- | --- | --- | --- |
| **Task**R = Right; L = Left; B = BothHand Dominance: [ ]  R [ ]  L | **Never** | **Seldom****1 – 10%****0 – 1 hour** | **Occasional****11 – 33%****1 – 3 hours** | **Frequent****34 – 66%****3 – 6 hours** | **Constant****67 – 100%****Not restricted** | **Not****Tested** |
| Perform Work on Ladders |  |  |  |  |  |  |
| Climb Ladders |  |  |  |  |  |  |
| Climb Stairs |  |  |  |  |  |  |
| Twist Neck |  |  |  |  |  |  |
| Twist Trunk |  |  |  |  |  |  |
| Bend/Stoop |  |  |  |  |  |  |
| Kneel |  |  |  |  |  |  |
| Squat [ ]  Partial [ ]  Full |  |  |  |  |  |  |
| Crawl – Distance:      ft. |  |  |  |  |  |  |
| Reach Forward |  |  |  |  |  |  |
| Reach Waist to Shoulder |  |  |  |  |  |  |
| Work Above Shoulders |  |  |  |  |  |  |
| Keyboarding |  |  |  |  |  |  |
| Wrist (Flexion/Extension) |  |  |  |  |  |  |
| Grasp (Forceful) |  |  |  |  |  |  |
| Handle/Grasp |  |  |  |  |  |  |
| Fine Manipulation |  |  |  |  |  |  |
| Operate Foot Controls |  |  |  |  |  |  |
| Vibrations – High Impact |  |  |  |  |  |  |
| Vibrations – Low Impact |  |  |  |  |  |  |
| Lifting – Floor       to Waist | [ ]  |       lbs. |       lbs. |       lbs. |       lbs. | [ ]  |
| Lifting – Waist to Shoulders | [ ]  |       lbs. |       lbs. |       lbs. |       lbs. | [ ]  |
| Lifting – Shoulder to Overhead | [ ]  |       lbs. |       lbs. |       lbs. |       lbs. | [ ]  |
| Lifting – Other:       | [ ]  |       lbs. |       lbs. |       lbs. |       lbs. | [ ]  |
| Carry – Distance:       ft. | [ ]  |       lbs. |       lbs. |       lbs. |       lbs. | [ ]  |
| Push – Dynamic Dist:       ft. | [ ]  |       lbs. |       lbs. |       lbs. |       lbs. | [ ]  |
| Pull – Dynamic Dist:       ft. | [ ]  |       lbs. |       lbs. |       lbs. |       lbs. | [ ]  |
| Other:       | [ ]  |         |         |         |         | [ ]  |
| **Comments:** |

**Signature**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|       |  |  |  | enter a date. |
| Print Therapist Name  |  | Therapist Signature |  | Date |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|       |  |  |  | enter a date. |
| Print Therapist Name  |  | Therapist Signature |  | Date |