**8.08 Burns (Skin Lesions) Evaluation and RFC**

Patient/Claimant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**A. Electrical, chemical, or thermal burns frequently affect other body systems; for example, musculoskeletal, special senses and speech, respiratory, cardiovascular, renal, neurological, or mental.**

1. Does the claimant have burns with extensive skin lesions or burns that have lasted or can be expected to last for a continuous period of at least 12 months? \_\_\_ Yes \_\_\_ No

a. Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.  *Symptoms (including pain).*

What are the patient’s Symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. *Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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What have been the effects of medication, therapy, surgery, and any other form of treatment the patient receives or received? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What has the patient’s respond to treatment been? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe any resistance to treatment and any side effects that can in themselves result in limitations. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the patient is in continuing treatment as prescribed has there been any improvement in the symptoms, signs, and laboratory findings of the patient’s disorder or any side effects that result in functional limitations? If so, please describe. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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i. What treatment has been prescribed? (for example, the type, dosage, method, and frequency of administration of medication or therapy);\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ii. Patient’s response to the treatment; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

iii. Any adverse effects of the treatment; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

iv. The expected duration of the treatment. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Please provide the following information about the onset, duration, frequency of the claimant’s flare-ups, and prognosis of your skin disorder; the location, size, and appearance of lesions; and, as applicable, a history of exposure to toxins, allergens, or irritants, familial incidence, seasonal variation, stress factors, and patient’s ability to function outside of a highly protective environment. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Please provide and attach any laboratory findings, for example, results of a biopsy or blood tests or evidence from other medically acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

**B. *Extensive Skin Lesions***

“Extensive skin lesions” are those that involve multiple body sites or critical body areas, and result in a very serious limitation. Extensive skin lesions are those that result in a very serious limitation include but are not limited to the following listed below:

1. Skin lesions that interfere with the motion of the patient’s joints and that very seriously limit his or her use of more than one extremity; that is, two upper extremities, two lower extremities, or one upper and one lower extremity. Does the patient have? \_\_\_ Yes \_\_\_ No

2. Skin lesions on the palms of both hands that very seriously limit the patient’s ability to do fine and gross motor movements. Does the patient have? \_\_\_ Yes \_\_\_ No

3. Skin lesions on the soles of both feet, the perineum, or both inguinal areas that very seriously limit the patient’s ability to ambulate.

D. *Frequency of flare-ups.*

1. Does the patient have skin lesions, that prevents him or her from doing any gainful activity when considering his or her condition over time even though the patient may have some periods during which your condition is in remission? \_\_\_ Yes \_\_\_ No

2. How frequent and serious are the patient’s flare-ups? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. How quickly do they resolve? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**C. Duration**

1. Have the patient’s extensive skin lesions or burns persisted for at least 3 months despite continuing treatment as prescribed. \_\_\_ Yes \_\_\_ No

2. Does the patient suffer from flare-ups? \_\_\_ Yes \_\_\_ No

3. Are the flare-ups severe enough to render the patient unable to do any gainful activity for a continuous period of at least 12 months? \_\_\_ Yes \_\_\_ No

3. Can the patient be expected to be unable to do any gainful activity for a continuous period of at least 12 months?.

\_\_\_ Yes \_\_\_ No

**D. Residual Functional Capacity**

In order to consider the frequency of the claimant’s flare-ups when it is necessary to determine whether he or she has a severe impairment that results in the patient’s residual functional capacity.

1. To what degree can patient tolerate work stress (i.e., maintain persistence and pace required within the confines of competitive work)? \_\_\_ Incapable of “low stress” \_\_\_ Capable of “low stress” \_\_\_ Moderate stress \_\_\_ High stress work

 2. As a result of your patient’s impairments, estimate your patient’s functional limitations if your patient were placed **hypothetically** in a ***competitive work situation****:*

 a. How many blocks can the patient reasonably walk without rest or significant pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ blocks

 b. Please circle the hours and/or mins. that the patient can **sit comfortably *at one time,*** without significant distraction from pain or symptomatology before needing to get up, etc.: **Sit**: 0 5 10 15 20 30 45 **Minutes** 1 2 **Hrs.**  **>** than 2 **Hrs**

c. Please circle the hrs. and/or mis. that your patient can **stand** ***at one time***, e.g., before needing to sit or, walk around, etc.

**Stand**: 0 5 10 15 20 30 45 **Minutes** 1 2 **Hrs** More than 2 **Hours**

d. Please indicate how long your patient can **sit** and **stand/walk** ***total in an 8-hour working day*** (with normal breaks)

 **Sit Stand/Walk**

\_\_\_ \_\_\_ less than 2 hours

\_\_\_ \_\_\_ about 2 hours

\_\_\_ \_\_\_ about 4 hours

\_\_\_ \_\_\_ at least 6 hours

 e. Does patient require periods of walking around during an 8hr. working day ?\_\_\_\_ yes \_\_\_\_ no

 1) If yes, how *often* must your patient walk? 1 5 10 15 20 30 45 60 90 **Minutes**

 2) Length of walk each time? 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 **Minutes**

 f. Does patient need job permitting shifting positions at *will* ? \_\_\_\_ yes \_\_\_\_ no

 g. Will patient need **unscheduled breaks** in an 8-hour work day? \_\_\_\_ yes \_\_\_\_ no

 If Yes, please answer 1) & 2) below.

 1) How *often* do you think this will happen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2) What is the average length of time the pt will have to **rest** before returning to work? \_\_\_\_ **Mins**  \_\_\_\_ **Hrs**

 h. With prolonged sitting, will patient’s leg(s) need **elevation** at/above waist level? \_\_\_\_ yes \_\_\_\_ no

1) What ***percentage of time***during an 8-hour working day should the patient’s leg(s) be elevated? \_\_\_\_\_\_\_**%**

 2) Will the patient use a cane or other assistive device? \_\_\_\_ yes \_\_\_\_ no

*Regarding the questions contained within this form “****Rarel****y” means 1% to 5%:“****Occasionall****y” means 6% to 33%;“****Frequentl****y” means 34% to 66%:“****Constantly****” means 67% or more of an 8-hour working day.*

 3. a. How many pounds can your patient **lift** and **carry** in a **competitive** work situation?

 **Never Rarely**  **Occasionally Frequently**

 Less than 10 lbs. \_\_ \_\_ \_\_ \_\_

10 lbs. \_\_ \_\_ \_\_ \_\_

20 lbs. \_\_ \_\_ \_\_ \_\_

50 lbs. \_\_ \_\_ \_\_ \_\_

 b. How often can your patient perform the following activities?

 **Never Rarely Occasionally Frequently**

 Look down (sustained) \_\_ \_\_ \_\_ \_\_

 Turn head right or left \_\_ \_\_ \_\_ \_\_

 Look up \_\_ \_\_ \_\_ \_\_
Hold head in static \_\_ \_\_ \_\_ \_\_

 Position

 c. How often can the individual perform the following *Physical Functions*?

 **Never Rarely** **Occasionally Frequently**

Reaching \_\_ \_\_ \_\_ \_\_

Handling \_\_ \_\_ \_\_ \_\_

Feeling \_\_ \_\_ \_\_ \_\_

Pushing/Pulling \_\_ \_\_ \_\_ \_\_

Hearing \_\_ \_\_ \_\_ \_\_

Speaking \_\_ \_\_ \_\_ \_\_

 d. How often can your patient perform the following activities?

 **Never Rarely Occasionally Frequently**

Twist \_\_ \_\_ \_\_ \_\_

Stoop (bend) \_\_ \_\_ \_\_ \_\_

Crouch/squat \_\_ \_\_ \_\_ \_\_

Climb ladders \_\_ \_\_ \_\_ \_\_

Climb stairs \_\_ \_\_ \_\_ \_\_

Kneel \_\_ \_\_ \_\_ \_\_

Crawl \_\_ \_\_ \_\_ \_\_

Balance \_\_ \_\_ \_\_ \_\_

e. Does the patient have any limitations w/ **reaching**, **handling** or **fingering**? \_\_\_\_ yes \_\_\_\_ no

 If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 f. How frequently during a typical workday how would you reasonably anticipate that your patient’s experience of pain or other symptoms including the effects or side effects of medications would be severe enough to interfere with **attention and concentration** needed to perform even simple repetitive tasks?

 \_\_ **Never** \_\_ **Rarely** \_\_ **Occasionally** \_\_ **Frequently** \_\_ **Constantly**

4. Will patient’s condition produce “good days” and “bad days”? \_\_\_\_ yes \_\_\_\_ no

 If yes, please estimate, on the average, how many days per month your patient is likely to be absent from work as a result of the impairments or need for treatment.

 \_\_ **never** \_\_ **about 1 day/mo.** \_\_ **about 2 days/mo.** \_\_ **about 3 days/mo.** \_\_ **about 4 days/mo.** \_\_ **more than 4 days/mo.**

5. Please describe any other limitations (such as psychological limitations, vision, hearing, need to avoid temperature extremes, wetness, humidity, noise, dust, fumes, gases, heights or hazards, etc.) that would affect your patient’s ability to work at a regular job on a sustained basis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. **What is the earliest date the symptoms and limitations described above in this questionnaire apply?**

  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Earliest Date of Application of symptoms and limitations above)**

**Physician’s Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed/Typed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Date** **Completed**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Or Please Attach Physician’s Business Card hereunder.**

Please Return from to:

Mike Murburg, P.A.
15501 N. Florida Ave.

Tampa, FL 33613

Tel (813) 264-5363

Fax (813) 961-6011