(Your logo here)

**Functional Abilities Determination**

**Informed Consent**

You have been asked to participate in a Functional Abilities Determination. This is often called a Functional Capacity Evaluation (FCE), a Return-to-Work Evaluation (RTW) or a Fit for Work Exam. An Abilities Determination is a series of tests including strength, range of motion and cardio, that takes place in 2 to 4 hours and is used to help determine your safe abilities to perform work related activities.

Testing includes some or all the following tasks:

o Medical History

o Physical Exam

o Cognitive Assessment

o Measurement of Range of Motion

o Measurement of Back Strength

o Grip and Pinch Strength

o Special Tests related to your Diagnosis

o Lifting, Carrying, Pushing and Pulling

o Functional activities such as walking, standing, sitting, bending, reaching, crouching, kneeling, stooping, handling & fingering.

Each test is voluntary, and you may refuse any test if you feel you are unable to perform it. We ask that you provide the evaluator with honest feedback as to how you are doing as it relates to pain, fatigue and any other symptoms you may have. We ask for your cooperation to provide your best, safe effort with each of the functional tasks.

As with any physical exertion there is some risk for injury. Your evaluator will take every precaution to ensure your safety. Some soreness is not unusual a day or two after testing. If you have any questions, please feel free to ask your evaluator. If you have any concerns that require immediate attention, please contact your physician or local emergency room.

By affixing your signature below, it implies that you have read the above information and have had any questions you might have answered fully. Your signature also implies permission for digital images to be taken to supplement the report and confirm your identification and functional abilities. We will make every effort possible in collecting fees due from the insurance organization provided. Should this not be possible then the fees due are the sole responsibility of the client evaluated. By signing this you are authorizing the representative for this clinic to sign for, and to be paid directly by the Insurance Entity. (Health Insurance Claim Form1500 Box:13, No for Assignment, Box: 27).

Client: (sign) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Evaluator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*****(your clinic address and contact information here)*