Limited capability for work questionnaire

The Pension Service 11
Mail Handling Site A
Wolverhampton
WV98 1LW
United Kingdom

Department for Work & Pensions

We need you to fill in this questionnaire if you have claimed or are getting benefits or National Insurance credits. Please fill it in with BLACK INK.

Please send this form back as soon as you can. If you do not send it back within 4 weeks you might lose benefit. If you are sending the form in late we need to know why. You can use the space on Page 19 to explain.

You may wish to fill in this form a bit at a time as it may take some time to complete.

If we are able to get enough information about you from this form, your doctor or the person treating you, we may not need to ask you to attend a medical assessment.

About you

Surname or family name

All other names, in full

Title Mr/Mrs/Miss/Ms

Address

Daytime phone number Code Number

Date of birth Day Month Year / /

National Insurance (NI) number Letters Numbers Letter

About you – continued

For people filling in this form for someone else
If you are filling in this form for someone else, please tell us some details about you.

Your name

Your address

Daytime phone number

Code Number

Explain why you are filling in this form for someone else, which organisation, if any, you represent, or your connection to the person the form is about.

Medical assessments

You may be asked to go for a medical examination by a doctor. Use the space below to tell us about any special needs you would have if you were asked to go to an examination.
Tell us about things like

- if you have difficulties walking up and down stairs
- if you must have someone to go with you because of your medical condition.

About you – continued

Are you getting Disability Living Allowance?

- **No** ○
- **Yes** ○

If yes, how much do you get? :

Do you get the Mobility component?
That is help with getting around.

- **No** ○
- **Yes** ○

If yes, what is the amount paid?

- **Lower** ○
- **Higher** ○

Do you get the Care component?
That is help with personal care.

- **No** ○
- **Yes** ○

If yes, what is the amount paid?

- **Lower** ○
- **Middle** ○
- **Higher** ○

About your illness or disabilities

We will ask you how your illnesses or disabilities affect how you do day-to-day things in the rest of this questionnaire.

Please use the space below to tell us

- **what is your disability, illness, or condition, and**
- **how does it affect you**

Please also tell us about

- any aids you use, such as a wheelchair or hearing aid
- if you have had a heart attack, stroke, accident or something similar. Please tell us when this happened
- anything else you think we should know about your illness or disabilities.

If at any point you need more space, use the space on **Page 19.**

About you – continued

About your care, support and treatment

Name of your doctor

Address of your doctor

Doctor's phone number

Code Number

When was your most recent appointment?

Day Month Year

/ /

Are you getting care, support or treatment from anyone else?

Tell us who they are.
For example:

- physiotherapist
- community psychiatric nurse
- social worker
- occupational therapist
- support worker.

Their address

Their phone number

Code Number

Other number

Code Number

What was your most recent appointment?

Day Month Year

/ /

If you need more space, use the box on **page 19.**

About you – continued

Are you having any hospital or clinical treatment?

No ○

Yes ○

If **yes**, tell us about this.

Do you attend as a day patient or out patient?

No ○

Yes ○

What do you attend the hospital or clinic for?

Name of hospital doctor or consultant

Name and address of hospital

If you attend more than one hospital or clinic, please use the box on **page 19** to give us more details.

Cancer treatment

Are you having, waiting for or recovering from chemotherapy or radiotherapy treatment for cancer?

No ○

Yes ○

If your single health problem is cancer treatment and its effects on you, you do not have to complete the rest of the questionnaire if you don't want to.
If you have other health problems as well as cancer treatment, please complete the rest of the questionnaire.
In either case, make sure you sign **page 20** and make sure **page 22** is filled in by a healthcare professional.

About your medication

Details of tablets or other medication
Please also tell us about any tablets or other medication you are taking or will be taking, including any side effects you have.

If you need more space, please use **page 19** or a separate sheet of paper.

● **About you** – continued

Have you been in hospital as an in-patient in the last 3 months?
If **yes**, tell us about this.

No ○
Yes ○

What date did you go into hospital?

Day Month Year
/ /

What date did you come out of hospital?

Day Month Year
/ /

If you are not sure of the dates, tell us how long you were in hospital for

Name and address of the hospital

Tell us what you were in hospital for.
Tell us about any operations and clinical treatment you had and the date you had them.

Do you expect to go into hospital as an in-patient in the next 3 months?
If **yes,** tell us about this.

No ○
Yes ○

What date do you expect to go in?

Day Month Year
/ /

Name and address of the hospital

Tell us what you are going into hospital for. If you expect to have an operation or clinical treatment, tell us what the operation is for and the date you expect to have it.

● About you – continued

Are you pregnant?

No ○

Yes ○

If **yes**, what date is the baby due?

Day Month Year

/ /

Drugs, alcohol or other substances

Do you think any of your health problems are linked to drug or alcohol misuse, or misuse of any other substance?

No ○

Yes ○

If you answered **yes**, use this space to tell us more about these problems and how they affect your health.
By drugs we mean drugs you get from your doctor and other drugs.

● How to fill in the rest of this form

The answers you give in the rest of this form will tell us how your illness or disability affects your ability to work.

This form may seem long, but do not be put off. Every question has instructions to take you step-by-step to the end of the form.

Use the boxes after each question to tell us in your own words how your illness or disability affects you in doing day-to-day things.

If you have an artificial limb or something like this, we need to know about the difficulties you have when you are wearing it.

You do not need to try the activities we ask about in the form. Tell us whether or not you **could** do them, based on your experience of the illness or disability.

If you tick the first box, to tell us you have no difficulties, you can go straight to the next numbered question.

Part 1 Physical functions

1. Moving around and using steps

By moving we mean including the use of aids such as a manual wheelchair, crutches or a walking stick, if you usually use one, but without the help of another person.

Please tick this box if you can move around and use steps without difficulty.

○ **Now go to question 2.**

How far can you move safely and repeatedly on level ground without needing to stop?
For example, because of tiredness, pain, breathlessness or lack of balance

○ **50 metres** - this is about the length of 5 double-decker buses, or twice the length of an average public swimming pool

○ **100 metres** - this is about the length of a football pitch

○ **200 metres or more**

○ **It varies**

Use this space to tell us how far you can move and why you might have to stop. For example tiredness or discomfort.
If it varies, tell us how.

Tell us if you usually use a walking stick, crutches, a wheelchair or anything else to help you, and tell us how it affects the way you move around

Going up or down two steps

Can you go up or down two steps without help from another person, if there is a rail to hold on to?

○ **No**

○ **Yes** **Now go to question 2.**

○ **It varies**

Use this space to tell us more about using steps.
If it varies, tell us in what way.

Part 1 Physical functions – continued

2. Standing and sitting

Tick this box if you can stand and sit without any difficulty.

○ **Now go to question 3.**

Can you move from one seat to another right next to it without help from someone else?

- **No** ○
- **Yes** ○
- **It varies** ○

How long can you stay in one place either standing, sitting, or a combination of the two, without help from another person, without pain or exhaustion?
This does not mean standing completely still. It includes being able to change position.

- **Less than 30 minutes** ○
- **30 minutes to one hour** ○
- **More than one hour** ○
- **It varies** ○

Use this space to tell us more about standing and sitting and why this might be difficult for you. Tell us how long you can sit for and how long you can stand for. Tell us what might make it difficult for you, such as pain, discomfort or tiredness. If it varies, tell us how

3. Reaching

Tick this box if you can reach up with your arms without any difficulty.

○ **Now go to question 4.**

Can you lift at least one of your arms high enough to put something in the top pocket of a coat or jacket while your are wearing it?

- **No** ○
- **Yes** ○
- **It varies** ○

Can you lift one of your arms above your head?

- **No** ○
- **Yes** ○
- **It varies** ○

Part 1 Physical functions – continued

3. Reaching – continued

Use this space to tell us more. Tell us why you might not be able to reach up, and whether if it affects both arms. If it varies, tell us in what way.

4. Picking up and moving things

Tick this box if you can pick things up and move things without any difficulty. ◯ **Now go to question 5.**

Picking up things using your upper body and either arm

Can you pick up and move a half-litre (one pint) carton full of liquid?

- **No** ◯
- **Yes** ◯
- **It varies** ◯

Can you pick up and move a litre (two pint) carton full of liquid?

- **No** ◯
- **Yes** ◯
- **It varies** ◯

Can you pick up and move a large, light object like an empty cardboard box?

- **No** ◯
- **Yes** ◯
- **It varies** ◯

Use this space to tell us more about picking things up and moving them. Tell us why you might not be able to pick things up. If it varies, tell us how.

Part 1 Physical functions – continued

5. Manual Dexterity (Using your hands)

Tick this box if you can use your hands without any difficulty.

Now go to question 6.

Can you use either hand to do things like:

- press a button, such as a telephone keypad
- turn the pages of a book
- pick up a £1 coin
- use a pen or pencil
- use a computer keyboard or computer mouse

Some of them

None of them

It varies

Use this space to tell us more. Tell us which of these you might have problems with and why. If it varies, tell us how.

6. Communicating with people

This section looks at how you communicate using speech, writing and typing

Please tick this box if you can communicate with other people without any difficulty

Now go to question 7.

Can you communicate a simple message to other people such as the presence of something dangerous?
This can be by speaking, writing, typing or any other means, but without the help of another person.

No

Yes

It varies

Use this space to tell us more. Tell us which of these you might have problems with and why. If it varies, tell us how.

7. Other people communicating with you

This section looks at how you understand other people by hearing and reading.

Please tick this box if you can understand other people without any difficulty. ◯ **Now go to question 8.**

Can you understand simple messages from other people by hearing or lip reading without the help of another person?
A simple message means things like the location of a fire escape.

- **No** ◯
- **Yes** ◯
- **It varies** ◯

Can you understand simple messages from other people by reading large size print or using Braille?

- **No** ◯
- **Yes** ◯
- **It varies** ◯

Use this space to tell us more. Tell us if you can hear, lip read, read or understand people in another way, or why you might not be able to. Tell us about any aids you use, such as a hearing aid. If it varies tell us how.

8. Getting around safely

This section looks at visual problems. If you normally use glasses or contact lenses, a guide dog or any other aid, tell us how you manage when you are using them. Please also tell us how you see in daylight or bright electric light.

Please tick this box if you can get around safely on your own. ◯ **Now go to question 9.**

Can you see to cross the road on your own

- **No** ◯
- **Yes** ◯
- **It varies** ◯

Can you get around a place that you haven't been to before without help?

- **No** ◯
- **Yes** ◯
- **It varies** ◯

Part 1 Physical functions – continued

Use this space to tell us more about any problems with your eyesight and how they stop you finding your way around safely.

9. Controlling your bowels and bladder and using a collecting device

Please tick this box if you can control your bowels and bladder without any difficulty. ◯ **Now go to question 10.**

Do you have to wash or change your clothes because of difficulty controlling your bladder, bowels or collecting device?
Collecting devices include stoma bags and catheters

Weekly ◯

Monthly ◯

Less often ◯

Use this space to tell us more about controlling your bowels and bladder and managing your collecting device. Tell us how often you might need to change your clothes or wash because of soiling, wetting or leakages.

Part 1 Physical functions – continued

10. Staying conscious when awake

Tick this box if you do not have any problems staying conscious while awake. ◯ **Now go to question 11 part 2.**

While you are awake, how often do you have fits or blackouts?
This includes epileptic fits and absences, and diabetic hypos.

Weekly ◯

Monthly ◯

Less often ◯

Use this space to tell us more.

Part 2 Mental, cognitive and intellectual functions

To answer Yes to any of the following questions, you must be able to do the activity safely, to an acceptable standard, as often as you need to and in a reasonable length of time.
By mental, cognitive and intellectual functions we mean things like mental illness, learning difficulties and the effects of head injuries.

● 11. Learning how to do tasks

Please tick this box if you can learn how to do everyday tasks without difficulty. ◯ **Now go to question 12.**

Can you learn how to do a simple task such as setting an alarm clock?

No ◯
Yes ◯
It varies ◯

Can you learn how to do a more complicated task such as using a washing machine?

No ◯
Yes ◯
It varies ◯

Use this space to tell us about any difficulties you have learning to do new things, and why you find it difficult.

● 12. Awareness of hazard or danger

Please tick this box if you can stay safe when doing everyday tasks such as boiling water or using sharp objects ◯ **Now go to question 13.**

Do you need supervision (someone to stay with you) for most of the time to stay safe

No ◯
Yes ◯
It varies ◯

Use this space to tell us about any difficulties you have learning to do new things, and why you find it difficult.

Part 2 Mental, cognitive and intellectual functions – continued

13. Starting and finishing tasks

This section is about whether you can manage to start and complete daily routines and tasks like getting up, washing and dressing, cooking a meal or going shopping.

Please tick this box if you manage to do daily tasks without difficulty. ◯ **Now go to question 14.**

Can you manage to plan, start and finish daily tasks?

Never ◯

Sometimes ◯

It varies ◯

Use this space to tell us what difficulties you have doing your daily routines. For example, remembering to do things, planning and organising how to do them, and concentrating to finish them.
Tell us what might make it difficult for you and how often you need other people to help you.

14. Coping with change

Please tick this box if you can cope with change to your daily routine. ◯ **Now go to question 15.**

Can you cope with small changes to your routine if you know about them before they happen?
For example, things like having a meal earlier or later than usual, or an appointment time being changed.

No ◯

Yes ◯

It varies ◯

Can you cope with small changes to your routine if they are unexpected.
This means things like appointments being cancelled, or a bus or train not running on time.

No ◯

Yes ◯

It varies ◯

Use this space to tell us more about how you cope with change. Explain your problems, and give examples if you can.

Part 2 Mental, cognitive and intellectual functions – continued

15. Going out

This question is about your ability to cope **mentally** or **emotionally** with going out. If you have **physical** problems which mean you can't go out, you should tell us about this in **Part 1** of the questionnaire.

Please tick this box if you can go out on your own ○ **Now go to question 16.**

Can you leave home and go out to places you know?

- ○ **No**
- ○ **Yes, if someone goes with me**
- ○ **It varies**

Can you leave home and go to places you don't know?

- ○ **No**
- ○ **Yes, if someone goes with me**
- ○ **It varies**

Use this space to tell us why you cannot always get to places. Tell us whether you need someone to go with you.

16. Coping with social situations

By social situations we mean things like meeting new people and going to meetings or appointments.

Please tick this box if you can cope with social situations without feeling too anxious or scared. ○ **Now go to question 17.**

Can you meet with people you know without feeling too anxious or scared?

- ○ **No**
- ○ **Yes**
- ○ **It varies**

Can you meet with people you don't know without feeling too anxious or scared?

- ○ **No**
- ○ **Yes**
- ○ **It varies**

Part 2 Mental, cognitive and intellectual functions – continued

● 16. Coping with social situations – continued

Use this space to tell us why you find it distressing to meet other people and what makes it difficult. Tell us how often you feel like this.

● 17. Behaving appropriately with other people

This section looks at whether your behaviour upsets other people.

Please tick this box if your behaviour does not upset other people. ○ **Now go to question 18 part 3.**

How often do you behave in a way which upsets other people?
For example, this might be because you are aggressive or act in an unusual way.

- **Everyday** ○
- **Often** ○
- **Occasionally** ○

Use this space to tell us why your behaviour upsets other people or why you get upset about things. Tell us how this happens.

Part 3 Eating and drinking

● 18. Eating and drinking

Can you get food and drink to your mouth without help or prompting from another person?

- **No** ○
- **Yes** ○
- **It varies** ○

Can you chew or swallow food and drink without help or prompting from another person?

- **No** ○
- **Yes** ○
- **It varies** ○

Part 3 Eating and drinking – continued

Use this space to tell us about how you eat and drink, and why you might need help.

Other information

Use this space to tell us either why your form is being sent in late or anything else you think we might need to know.

Declaration

- **I declare** that the information I have given on this form is correct and complete as far as I know and believe.

- **I understand** that if I knowingly give information that is incorrect or incomplete, I may be liable to prosecution or other action.

- **I understand** that I must promptly tell the office that pays my benefit of anything that may affect my entitlement to, or the amount of, that benefit.

- **I agree** that
  - the Department for Work and Pensions
  - any health care professional or doctor advising the Department
  - any organisation with which the Department has a contract for the provision of medical services may ask any of the people or organisations mentioned on this form for any information which is needed to deal with
  - this claim for benefit
  - any request for this claim to be looked at again,

  and that the information may be given to that health care professional, doctor or organisation or to the Department or any other government department as permitted by law.

- **I also understand** that the Department may use the information which it has now or may get in the future to decide whether I am entitled to
  - the benefit I am claiming
  - any other benefit I have claimed
  - any other benefit I may claim in the future.

You must sign this form yourself if you can, even if someone else has filled it in for you.

Signature

Your full name

Day Month Year

Date / /

What to do next

Please make sure that:

- you have answered all the questions on this form that apply to you
- you have signed and dated this form.

What to do when you have signed this form

Take this form to your doctor. Ask the doctor to fill in **Part 4** of the form (last page) and give it back to you. You must then send the form back to us in the envelope we sent you.

Tick this box if you are including any medical reports ○

Notes for the doctor who fills in Part 4

Your patient named on **page 1** has claimed Employment and Support Allowance from The Pension Service (part of the Department for Work and Pensions in the United Kingdom).

Our rules mean we need to ask the patient's doctor for information about the customer's medical condition and the disabling effects of the condition. Please fill in **Part 4** of the form (last page) and give the form back to your patient who will send it back to us.

● **Cancer treatment** - for completion by a healthcare professional

The information you provide on this page is important as it will help the Department for Work and Pensions to make a rapid benefit decision for your patient.

This page concerns patients who are having, waiting for or recovering from (post completion of treatment) chemotherapy or radiotherapy.

Please complete the rest of this page. If you have any queries, please visit:
www.dwp.gov.uk/healthcare-professional/guidance/atos-healthcare

Details of cancer diagnosis
Include:
- type and site
- stage
- any related diagnoses

Details of treatment
Include:
- regime
- expected duration

Is your patient:
(Please tick as appropriate)

- ○ awaiting or undergoing chemotherapy or radiotherapy?
- ○ recovering (post completion of treatment) from chemotherapy or radiotherapy

In your opinion, is it likely that the impact of the treatment has or will have work-limiting side effects?

No ○
Yes ○

In your opinion are these side effects likely to limit all work?
No ○
Yes ○

In your opinion how long would you expect these side effects to last?

Your details:

Name

Qualifications

Signature

Surgery stamp, hospital stamp or address details

Date

Day Month Year
/ /

Statement by the Customer's General Practitioner or Hospital Doctor

This statement should be completed in the light of your knowledge and records of your patient shown on **page 1**. It is **NOT** necessary to read through or comment on what your patient has said.

Diagnosis

Other conditions present

Disabling effects of medical condition

Additional remarks (please add anything that may help in assessing your patient's medical condition)

Signature

Address

Date

Day Month Year

/ /

Doctor's Name (capital letters)

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