

PHYSICAL MEDICAL SOURCE STATEMENT

From: _____

Re: _____ (Name of Patient)

_____ (Social Security No.)

Please answer the following questions concerning your patient's impairments. *Attach relevant treatment notes, radiologist reports, laboratory and test results as appropriate.*

1. Frequency and length of contact: _____

2. Diagnoses: _____

3. Prognosis: _____

4. List your patient's ***symptoms***, including pain, dizziness, fatigue, etc:

5. If your patient has pain, characterize the nature, location, frequency, precipitating factors, and severity of your patient's pain:

6. Identify the clinical findings and objective signs:

7. Describe the treatment and response including any side effects of medication that may have implications for working, *e.g.*, drowsiness, dizziness, nausea, etc:

8. Have your patient's impairments lasted or can they be expected to last at least twelve months? Yes No

9. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations? Yes No

10. Identify any psychological conditions affecting your patient's physical condition:

- | | |
|---|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Somatoform disorder | <input type="checkbox"/> Personality disorder |
| <input type="checkbox"/> Psychological factors affecting physical condition | <input type="checkbox"/> Other: _____ |

11. As a result of your patient's impairments, estimate your patient's functional limitations if your patient were placed in a **competitive work situation**.

a. How many city blocks can your patient walk without rest or severe pain? _____

b. Please circle the hours and/or minutes that your patient can sit **at one time**, e.g., before needing to get up, etc.

Sit: 0 5 10 15 20 30 45 1 2 More than 2
 Minutes Hours

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

Stand: 0 5 10 15 20 30 45 1 2 More than 2
 Minutes 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 | |
|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | less than 2 hours |
| <input type="checkbox"/> | <input type="checkbox"/> | about 2 hours |
| <input type="checkbox"/> | <input type="checkbox"/> | about 4 hours |
| <input type="checkbox"/> | <input type="checkbox"/> | at least 6 hours |

e. Does your patient need a job that permits shifting positions at will from sitting, standing or walking? Yes No

f. Does your patient need to include periods of walking around during an 8-hour working day? Yes No

| | |
|--|---|
| If yes, how often must your patient walk? | How long must your patient walk each time? |
| <u>1 5 10 15 20 30 45 60 90</u> | <u>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15</u> |
| Minutes | Minutes |

g. Will your patient sometimes need to take unscheduled breaks during a working day? Yes No

If yes, 1) how **often** do you think this will happen? _____

2) how **long** (on average) will your patient have to rest before returning to work? _____

3) what symptoms cause a need for breaks?

- | | |
|--|--|
| <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Pain/ paresthasias, numbness |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Adverse effects of medication |
| <input type="checkbox"/> Other: | _____ |

h. With prolonged sitting, should your patient's leg(s) be elevated? Yes No

If yes, 1) how **high** should the leg(s) be elevated? _____

2) if your patient had a sedentary job, **what percentage of time** during an 8-hour working day should the leg(s) be elevated? _____ %

3) what symptoms cause a need to elevate leg(s)? _____

i. While engaging in occasional standing/walking, must your patient use a cane or other hand-held assistive device? Yes No

If yes, what symptoms cause the need for a cane?

Imbalance Pain Weakness

Insecurity Dizziness

Other: _____

For this and other questions on this form, "rarely" means 1% to 5% of an 8-hour working day; "occasionally" means 6% to 33% of an 8-hour working day; "frequently" means 34% to 66% of an 8-hour working day.

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

| | Never | Rarely | Occasionally | Frequently |
|-------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Less than 10 lbs. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10 lbs. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20 lbs. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 50 lbs. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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

| | Never | Rarely | Occasionally | Frequently |
|---------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Twist | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stoop (bend) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Crouch/ squat | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Climb stairs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Climb ladders | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

l. Does your patient have significant limitations with reaching, handling or fingering?

Yes No

If yes, please indicate the percentage of time during an 8-hour working day that your patient can use hands/fingers/arms for the following activities:

| | <u>HANDS:</u> Grasp, Turn Twist Objects | <u>FINGERS:</u> Fine Manipulations | <u>ARMS:</u> Reaching In Front of Body | <u>ARMS:</u> Reaching Overhead |
|---------------|---|--|--|--------------------------------------|
| Right: | % | % | % | % |
| Left: | % | % | % | % |

m. How much is your patient likely to be **“off task”**? That is, what percentage of a typical workday would your patient’s symptoms likely be severe enough to interfere with **attention and concentration** needed to perform even simple work tasks?

- 0% 5% 10% 15% 20% 25% or more

n. To what degree can your patient tolerate work stress?

- Incapable of even "low stress" work Capable of low stress work
 Capable of moderate stress - normal work Capable of high stress work

Please explain the reasons for your conclusion: _____

o. Are your patient’s impairments likely to produce “good days” and “bad days”?

- Yes No

If yes, assuming your patient was trying to work full time, 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 treatment:

- Never About three days per month
 About one day per month About four days per month
 About two days per month More than four days per month

12. Are your patient's impairments (physical impairments plus any emotional impairments) as demonstrated by signs, clinical findings and laboratory or test results **reasonably consistent** with the symptoms and functional limitations described above in this evaluation?

- Yes No

If no, please explain: _____

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

Date

Signature

Printed/Typed Name: _____

Address: _____

