Medical Source Statement

From: _____ (Physician's Name)
Re: _____ (Name of Patient)
_____ (Date of Birth)

Please answer the following questions concerning your patient's impairments:

1. Frequency and length of contact: _____

2. Diagnoses: _____

3. Prognosis: _____

4. 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 (Minutes) 1 2 More than 2 (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 (Minutes) 1 2 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 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? 1 5 10 15 20 30 45 60 90 (Minutes)

   How ***long*** must your patient walk each time? 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 (Minutes)

g. In addition to normal breaks every two hours, will your patient sometimes need to take *unscheduled* breaks during a working day? ☐ Yes ☐ No

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

2) approx. how ***long*** (on average) will each break last?_____

3) what symptoms cause a need for breaks?

☐ Muscle weakness ☐ Pain/paresthesia, numbness
☐ Chronic fatigue ☐ Adverse effects of medication
☐ Other: _____

h. While engaging in occasional standing/walking, must your patient use a cane or other assistive device? ☐ Yes ☐ No

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.

i. 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.:	☐	☐	☐	☐

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

	Never	Rarely	Occasionally	Frequently
Look down (sustained flexion):	☐	☐	☐	☐
Turn head right or left:	☐	☐	☐	☐
Look up:	☐	☐	☐	☐
Hold head in static position:	☐	☐	☐	☐

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

	Never	Rarely	Occasionally	Frequently
Twist:	☐	☐	☐	☐
Stoop (bend):	☐	☐	☐	☐
Crouch/ squat:	☐	☐	☐	☐
Climb ladders:	☐	☐	☐	☐
Climb stairs:	☐	☐	☐	☐

l. Please indicate the percentage of time during an 8-hour working day that your patient can use hands/fingers/arms for the following activities:

	HANDS: Grasp, Turn Twist Objects	**FINGERS: Fine Manipulations**	**ARMS: Reaching In Front of Body**	**ARMS: 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. 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:

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

o. Does the patient require unscheduled rest breaks?

☐ No
☐ Yes, the patient requires rest breaks every _____hours/minutes
Due to _____.

5. 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: _____

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

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

☐ Depression
☐ Somatoform disorder
☐ Psychological factors affecting physical condition
☐ Anxiety
☐ Personality disorder
☐ Other:_____

8. 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:

_____

_____

9. Please cite any clinical findings that support the limitations you have identified above:

_____

_____

10. Please provide any other reasons why you believe the limitations above apply:

_____

_____

_____

_____

CERTIFICATION

By my signature below, I attest under 28 U.S.C. Sec. 1746(2) et seq., that the answers contained in this questionnaire are a true and accurate representation of my medical opinion, which I rendered based solely on my education, training, experience, and review of the medical evidence cited above.

_____ _____

Date Signature

_____

Printed Name

Address: _____

_____

_____