CARDIAC 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. Diagnosis (with New York Heart Association functional classification):

   _____

3. Prognosis: _____

4. Identify clinical findings, laboratory and test results that show your patient's impairments:

   _____

   _____

5. Identify your patient's signs and symptoms:

☐ Chest pain	☐ Anginal equivalent pain	☐ Chronic fatigue
☐ Weakness	☐ Exercise intolerance	☐ Nausea
☐ Arrhythmia	☐ Orthopnea	☐ Dizziness
☐ Exertional dyspnea	☐ Rest dyspnea	☐ Nocturia
☐ Loss of appetite	☐ Peripheral edema	☐ Pulmonary edema
☐ Syncope	☐ Near syncope	☐ Chronic cough
☐ Hepatomegaly	☐ Prinzmetal's angina	☐ Palpitations
☐ Paroxysmal nocturnal dyspnea		

   Other: _____

6. If your patient has angina:

   a. Describe nature, location and radiation of symptoms: _____

      _____

   b. How often do angina episodes typically occur? _____

   c. If your patient must typically rest after an episode of angina, how long will your patient typically rest? _____

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. a. What is the role of stress in bringing on your patient's symptoms?

_____

b. 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: _____

9. Do your patient's physical symptoms and limitations cause emotional difficulties such as depression or chronic anxiety? ☐ Yes ☐ No

Please explain: _____

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

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

12. 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 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

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

d. 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) on such a break, will your patient need to ☐ lie down or ☐ sit quietly?

e. 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 the leg(s)? _____

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.

f. 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.	☐	☐	☐	☐

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

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

h. State the degree to which your patient should avoid the following:

ENVIRONMENTAL RESTRICTIONS	**NO RESTRICTIONS**	**AVOID CONCENTRATED EXPOSURE**	**AVOID EVEN MODERATE EXPOSURE**	**AVOID ALL EXPOSURE**
Extreme cold	☐	☐	☐	☐
Extreme heat	☐	☐	☐	☐
High humidity	☐	☐	☐	☐
Wetness	☐	☐	☐	☐
Cigarette smoke	☐	☐	☐	☐
Perfumes	☐	☐	☐	☐
Soldering fluxes	☐	☐	☐	☐
Solvents/cleaners	☐	☐	☐	☐
Fumes, odors, gases	☐	☐	☐	☐
Dust	☐	☐	☐	☐
Chemicals	☐	☐	☐	☐
List other irritants:				
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐

i. 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

j. 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 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

13. 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: _____

14. Please describe any other limitations (such as psychological limitations, limited vision, difficulty hearing, etc.) that would affect your patient's ability to work at a regular job on a sustained basis:

_____

_____

_____

_____ _____

Date *Signature*

Printed/Typed Name: _____

Address: _____

_____

_____

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