PHYSICAL MEDICAL SOURCE STATEMENT

From: _____ (Doctor/Practice Name)

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

Sit:

1 5 10 15 20 30 45 60 90 120

Minutes

b. 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:

1 5 10 15 20 30 45 60 90 120

Minutes

c. 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

d. 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

e. 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?

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

f. Should your patient's leg(s) be elevated? ☐ Yes ☐ No

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

2) ***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)? _____

g. 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: _____

Does your patient need a cane or other hand-held assistive device for walking, standing or both? _____

Does your patient need a cane or other hand-held assistive device all of the time? _____

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.

h. 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.	☐	☐	☐	☐

i. 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:

	HANDS: Grasp, Turn Twist Objects	**FINGERS: Fine Manipulations**	**ARMS: Reaching In Front of Body**	**ARMS: Reaching Overhead**
Right:	**%**	**%**	**%**	**%**
Left:	**%**	**%**	**%**	**%**

j. 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

k. 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: _____

l. 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

9. 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: _____

10. 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: _____

_____

Note: Template was prepared by Liner Legal, LLC, but completed by signatory in compliance with SSA Rules and Regulations