VISION IMPAIRMENT 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, laboratory and test results as appropriate.*

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

1. Frequency and length of contact:_____
2. Diagnoses:_____
3. Prognosis:_____
4. Visual acuity after best correction right eye:_____
5. Visual acuity after best correction left eye: _____
6. Describe any contraction of peripheral visual fields:

_____

_____

_____

7. Describe your patient's vision ***symptoms***:

_____

_____

_____

_____

_____

_____

_____

"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.

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

   a. How often can your patient perform work activities involving the following?

	Never	**Rarely**	**Occasionally**	**Frequently**	**Constantly**
Near Acuity	☐	☐	☐	☐	☐
Far Acuity	☐	☐	☐	☐	☐
Depth Perception	☐	☐	☐	☐	☐
Accommodation	☐	☐	☐	☐	☐
Color Vision	☐	☐	☐	☐	☐
Field of Vision	☐	☐	☐	☐	☐

   b. Is your patient capable of avoiding ordinary hazards in the workplace, such as boxes on the floor, doors ajar, approaching people or vehicles? ☐ Yes ☐ No

   c.. Does your patient have any difficulty walking up or down stairs? ☐ Yes ☐ No

   d. Can your patient work with small objects such as those involved in doing sedentary work? ☐ Yes ☐ No

   e. Can your patient work with large objects? ☐ Yes ☐ No

9. Please identify any exertional limitations; and please explain the relationship of these limitations to your patient's vision:

   a. 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.	☐	☐	☐	☐

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

	Never	**Rarely**	**Occasionally**	**Frequently**
Stoop (bend)	☐	☐	☐	☐
Crouch/ squat	☐	☐	☐	☐

   c. Please explain the medical basis for the above limitations and whether they are related to your patient's eye problem:

_____

_____

_____

_____

10. Will your patient sometimes need to take unscheduled breaks during an 8-hour 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) please explain why such breaks are necessary:

_____

_____

11. 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

12. Please describe any other limitations 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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