LINER LEGAL
DISABILITY LAWYERS

AMPUTATION / ORTHOPEDIC INJURY MEDICAL SOURCE STATEMENT

Patient Name: _____ Date: _____

Provider Name / Specialty: _____

SECTION 1 — DIAGNOSIS AND DURATION

Primary Diagnoses (include level of amputation or nature of orthopedic injury): _____

_____

Date of surgery or injury:

Condition expected to last ≥ 12 months? ☐ Yes ☐ No

☐ Pain ☐ Fatigue ☐ Weakness ☐ Balance problems ☐ Skin breakdown ☐ Phantom sensations

☐ Residual limb tenderness ☐ Limited joint mobility ☐ Other: _____

SECTION 2 — SITTING, STANDING, AND WALKING TOLERANCE

For each activity below, check the total number of hours your patient can perform this activity in an 8-hour workday.

ACTIVITY	0	1	2	3	4	5	6+
SITTING	☐	☐	☐	☐	☐	☐	☐
STANDING	☐	☐	☐	☐	☐	☐	☐
WALKING	☐	☐	☐	☐	☐	☐	☐

Needs to alternate positions at will? ☐ Yes ☐ No

Needs to remove prosthesis periodically? ☐ Yes ☐ No

Needs to elevate residual limb? ☐ Yes ☐ No

Typical duration of prosthesis wear before removal (hours): _____

Supportive findings (pain, edema, fatigue, prosthetic irritation): _____

_____

SECTION 3 — PROSTHESIS OR ASSISTIVE DEVICE

Is a prosthesis or assistive device medically necessary? ☐ Yes ☐ No

Type:

☐ Lower-limb prosthesis ☐ Upper-limb prosthesis ☐ Cane ☐ Two canes ☐ Crutch(es) ☐ Walker

☐ Wheelchair ☐ Other: _____

When required:

☐ All ambulation ☐ Long distances ☐ Prolonged standing ☐ Balance support ☐ Flare-ups only

Can the patient safely carry objects while using the device? ☐ Yes ☐ No

Findings supporting medical necessity (limb loss, instability, pain, deformity): _____

_____

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SECTION 4 — LIFTING, CARRYING, AND MANIPULATIVE FUNCTION

WEIGHT	NEVER (0%)	OCCASIONAL (≤1/3)	FREQUENT (1/3–2/3)
<10 LBS	☐	☐	☐
10 LBS	☐	☐	☐
20 LBS	☐	☐	☐
50 LBS	☐	☐	☐

Compensatory overuse of intact limb or upper extremity symptoms? ☐ Yes ☐ No
If yes, describe: _____

Manipulative Limitations (Upper Extremities): _____

ACTIVITY	NEVER (0%)	OCCASIONAL (≤1/3)	FREQUENT (1/3–2/3)
HANDLING / GRASPING	☐ L ☐ R ☐ B	☐ L ☐ R ☐ B	☐ L ☐ R ☐ B
FINGERING / FINE MANIPULATION	☐ L ☐ R ☐ B	☐ L ☐ R ☐ B	☐ L ☐ R ☐ B
REACHING (FRONT / OVERHEAD)	☐ L ☐ R ☐ B	☐ L ☐ R ☐ B	☐ L ☐ R ☐ B

Supporting findings (shoulder limitation, grip loss, prosthetic tolerance, phantom limb pain): _____

SECTION 5 — ENDURANCE AND RELIABILITY

Unscheduled breaks? ☐ Yes ☐ No ☐ If yes, ≈ _____ breaks/day × _____ min each
Expected off-task time: ☐ ≤5% ☐ 10% ☐ 15% ☐ ≤20% ☐ 25% or more
Likely absences per month (if full-time): ☐ <1 ☐ 1 ☐ 2 ☐ 3 ☐ 4+
If any of the above apply, please explain the primary causes (e.g., pain, prosthetic fatigue, skin breakdown, residual limb swelling, instability): _____

SECTION 6 — CONSISTENCY WITH CLINICAL FINDINGS

Do the limitations described above reflect what you have consistently observed and documented during your treatment of this patient? ☐ Yes ☐ No ☐ Partially (explain): _____
Provider Signature: _____ Date: _____
Address / Phone: _____