LINER LEGAL
DISABILITY LAWYERS

AUTOIMMUNE DISORDERS
MEDICAL SOURCE STATEMENT

(Systemic Lupus Erythematosus • Rheumatoid Arthritis • Sjögren's Syndrome • Vasculitis)

Patient Name: _____ Date: _____

Provider Name /Specialty: _____

SECTION 1 — DIAGNOSIS AND DURATION

Autoimmune Diagnoses: _____

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

Symptoms attributable to autoimmune disease (check all that apply): _____

☐ Pain ☐ Fatigue ☐ Post-exertional decline ☐ Joint stiffness ☐ Swelling/synovitis

☐ Morning stiffness > 60 minutes ☐ Weakness ☐ Dry eyes/mouth (sicca) ☐ Numbness/Tingling

☐ Rash/photosensitivity ☐ Organ involvement (renal, pulmonary, cardiac, neuro) ☐ Fever

☐ Cognitive dysfunction ("brain fog") ☐ Other: _____

Relevant abnormal labs (if applicable):

ANA: _____ Anti-dsDNA: _____ ENA panel: _____ RF/CCP: _____ ESR/CRP: _____

C3/C4: _____ Other abnormalities: _____

SECTION 2 — SITTING, STANDING, AND WALKING TOLERANCE

Please indicate total time your patient can perform each 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 walk periodically during the day? ☐ Yes ☐ No

Explain if applicable (e.g., stiffness, fatigue, pain with prolonged positions): _____

_____

Supportive medical findings (e.g., synovitis, gait changes, reduced ROM, inflammatory pain): _____

_____

SECTION 3 — ASSISTIVE DEVICE (IF APPLICABLE)

Is a hand held assistive device medically necessary? ☐ Yes ☐ No

Type:

☐ Cane ☐ Two canes ☐ Crutch ☐ Two crutches ☐ Walker ☐ Wheelchair/Scooter ☐ Other: _____

When required:

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

Findings supporting medical necessity (e.g., instability from joint inflammation, fatigue, neuropathy): _____

_____

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SECTION 4 — AUTOIMMUNE FLARES

Frequency of clinically significant flares:

☐ Weekly ☐ Monthly ☐ Every 2–3 months ☐ Unpredictable

Typical flare duration:

☐ <24 hours ☐ 1–3 days ☐ 4–7 days ☐ >7 days

During flares, the patient experiences (check all):

☐ Increased pain ☐ Severe fatigue ☐ Joint swelling Cognitive dysfunction ☐ Reduced mobility

☐ Need for bedrest ☐ Inability to leave home ☐ Other: _____

Expected work absences due to flares:

☐ <1 day/month ☐ 1–2 ☐ 3–4 ☐ 5+ ☐ Unable to maintain reliable attendance

SECTION 5 — LIFTING, CARRYING, AND MANIPULATIVE FUNCTION

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

INSTRUCTIONS: If limitation applies to Left side, enter L. Right side, R. Both, B.

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

Findings supporting hand/arm limits from autoimmune disease (e.g., synovitis, erosions, swelling, fatigue):

_____

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SECTION 6 — ENDURANCE, FATIGUE, AND RELIABILITY

Unscheduled breaks? ☐ Yes ☐ No ☐ If yes, ≈_____ breaks/day × _____ minutes

Expected off-task time due to pain, fatigue, cognitive dysfunction, or flares:
☐ ≤5% ☐ 10% ☐ 15% ☐ ≤20% ☐ 25% or more

Likely absences per month (if full-time):
☐ <1 ☐ 1 ☐ 2 ☐ 3 ☐ 4+ ☐ Unable to sustain full-time attendance

Primary causes (check all):
☐ Pain Fatigue ☐ Immunosuppressant side effects ☐ Cognitive impairment ☐ Flares
☐ Organ ☐ involvement ☐ Other: _____

Medical findings contributing to reduced endurance or concentration:

SECTION 7 — CONSISTENCY

Do the functional 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:_____