LINER LEGAL
DISABILITY LAWYERS

ONCOLOGY
MEDICAL SOURCE STATEMENT

(Cancer: Solid Tumors • Hematologic Malignancies • Metastatic Disease • Treatment Toxicity)

Patient Name: _____ Date: _____

Provider Name / Specialty: _____

SECTION 1 — DIAGNOSIS AND DURATION

Cancer Diagnoses (type, stage, grade, sites of involvement): _____

Date of initial diagnosis: _____

Current cancer status: _____

☐ Active disease ☐ Remission ☐ Partial response ☐ Progressive disease

☐ Metastatic

Expected duration ≥ 12 months? ☐ Yes ☐ No ☐ Uncertain

Primary symptoms (check all that apply):

☐ Pain ☐ Fatigue ☐ Weight loss ☐ Nausea/vomiting ☐ Neuropathy

☐ Shortness of breath ☐ Cognitive difficulty ("chemo brain") ☐ Weakness

☐ Fever/night sweats ☐ Anemia ☐ Lymphedema ☐ GI disturbances

☐ Bone pain ☐ Other: _____

Relevant findings (if applicable): _____

Tumor markers: _____ Hematologic abnormalities: _____

Imaging results (summary): _____

Organ involvement (specify): _____

SECTION 2 — SITTING, STANDING, AND WALKING TOLERANCE

Indicate the 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 as needed? ☐ Yes ☐ No

Needs to walk periodically? ☐ Yes ☐ No

Explanation (fatigue, weakness, treatment effects, pain, etc.): _____

_____

Supportive findings (e.g., weakness, anemia, bone metastases, neuropathy): _____

_____

LINER LEGAL
DISABILITY LAWYERS

ONCOLOGY
MEDICAL SOURCE STATEMENT
(Cancer: Solid Tumors • Hematologic Malignancies • Metastatic Disease • Treatment Toxicity)

SECTION 3 — ASSISTIVE DEVICE (IF APPLICABLE)

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

Type:

☐ Cane ☐ Crutch ☐ Walker ☐ Wheelchair ☐ Scooter

☐ Other: _____

When required:

☐ All ambulation ☐ Long distances ☐ Limited endurance ☐ Pain control ☐ Balance support

Findings supporting necessity: _____

SECTION 4 — CANCER TREATMENT AND SIDE EFFECTS

Current or recent treatments (check all):

☐ Chemotherapy ☐ Immunotherapy ☐ Targeted therapy ☐ Radiation Surgery

☐ Bone marrow / stem cell transplant ☐ Hormonal therapy ☐ Clinical trial

Treatment frequency: _____

Significant side effects (check all):

☐ Severe fatigue ☐ Nausea/vomiting ☐ Diarrhea ☐ Cognitive dysfunction ☐ Neuropathy ☐ Pain

☐ Weight loss ☐ Immune suppression/infection risk ☐ Anemia ☐ Dehydration

☐ Other: _____

Impact on functional ability (e.g., days of recovery after treatment): _____

SECTION 5 — LIFTING, CARRYING, AND MANIPULATIVE FUNCTION

Weight Limits

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

INSTRUCTIONS: L = Left R = Right B = Both

Manipulative Limits

ACTIVITY	NEVER	OCCASIONAL	FREQUENT	CONSTANT
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 limitations (e.g., neuropathy, bone pain, surgical effects, stiffness): _____

LINER LEGAL
DISABILITY LAWYERS

ONCOLOGY
MEDICAL SOURCE STATEMENT
(Cancer: Solid Tumors • Hematologic Malignancies • Metastatic Disease • Treatment Toxicity)

SECTION 6 — ENDURANCE, FATIGUE, COGNITIVE FUNCTION, AND RELIABILITY

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

Expected off task time due to symptoms or treatment effects:

☐ <5% ☐ 10% ☐ 15% ☐ 20% ☐ 25% or more

Likely absences per month:

☐ <1 ☐ 1 ☐ 2 ☐ 3 ☐ 4+ ☐ Unable to sustain full time attendance

Primary causes (check all):

☐ Pain ☐ Fatigue ☐ Immunosuppressant side effects ☐ Cognitive impairment

☐ Infections ☐ Nausea/GI effects ☐ Organ involvement ☐ Other: _____

COGNITIVE WORK CAPACITY (CANCER RELATED COGNITIVE IMPAIRMENT / "CHEMO BRAIN")

Please estimate based on typical performance over a month.

Ability to maintain attention/concentration for uninterrupted periods:

☐ 5 minutes ☐ 10 minutes ☐ 15 minutes ☐ 30 minutes ☐ 45 minutes ☐ 60+ minutes

Expected off task time due specifically to cognitive symptoms (processing speed, memory lapses, slowed thinking): _____

☐ <5% ☐ 10% ☐ 15% ☐ 20% ☐ 25% ☐ 30%+ of a workday

Ability to perform work requiring pace or production quotas:

☐ Able to maintain normal pace ☐ Cannot sustain competitive pace for 2 hour periods

☐ Requires slower than average pace ☐ Cannot sustain competitive pace at all

Short term memory reliability:

☐ No issues ☐ Mild lapses ☐ Frequent lapses interfering with tasks

☐ Unable to remember simple instructions consistently

Need for unscheduled breaks due to cognitive fatigue:

☐ None ☐ 1–2/day ☐ 3–4/day ☐ More than 4/day

Medical findings contributing to reduced endurance or concentration: _____

_____

SECTION 7 — CONSISTENCY

Do the limitations described above reflect what you have consistently observed?

☐ Yes ☐ No ☐ Partially (explain below)

Explanation (if needed): _____

_____

Provider Signature: _____ Date: _____

Address / Phone: _____