LINER LEGAL
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STROKE / CEREBROVASCULAR ACCIDENT (CVA) MEDICAL SOURCE STATEMENT

Patient Name: _____ Date: _____

Provider Name / Specialty: _____

SECTION 1 — DIAGNOSIS, DATE OF EVENT, AND DURATION

Stroke / CVA diagnosis confirmed by neuroimaging? ☐ Yes ☐ No

Date of stroke / cerebrovascular event: _____

Type of event (if known):

☐ Ischemic ☐ Hemorrhagic ☐ TIA with persistent deficits ☐ Other: _____

Residual deficits have persisted for ≥ 12 months since the event? ☐ Yes ☐ No

Overall course since stroke:

☐ Improved but residual deficits persist ☐ Stable residual deficits ☐ Fluctuating / episodic worsening

SECTION 2 — MOTOR AND SENSORY RESIDUAL DEFICITS

Documented post-stroke motor or sensory deficits (check all that apply):

☐ Hemiparesis ☐ Unilateral weakness ☐ Spasticity ☐ Abnormal gait

☐ Balance impairment ☐ Coordination deficits ☐ Sensory loss

☐ Fine motor impairment ☐ Visual field deficit ☐ Neglect

Supporting findings (exam findings, imaging, therapy records): _____

SECTION 3 — COGNITIVE, COMMUNICATIVE, AND NEUROBEHAVIORAL RESIDUALS

Documented cognitive or communicative deficits (if present):

☐ Memory impairment ☐ Slowed processing speed ☐ Reduced attention/concentration

☐ Executive dysfunction ☐ Aphasia ☐ Dysarthria

☐ Apraxia ☐ Reduced judgment or safety awareness

Supporting findings (neuropsych testing, speech therapy, clinical observation): _____

SECTION 4 — FATIGUE, VARIABILITY, AND WORK SUSTAINABILITY

Typical baseline fatigue or endurance level:

☐ Mild ☐ Moderate ☐ Severe ☐ Very severe / disabling

Symptom variability: _____

How often do physical or cognitive symptoms unpredictably worsen?

☐ Daily ☐ Several times per week ☐ Weekly ☐ Monthly ☐ Unpredictable

When symptoms worsen, the patient is unable to reliably (check all that apply):

☐ Maintain attention or pace ☐ Follow simple instructions ☐ Sustain physical activity

☐ Walk safely or efficiently ☐ Use upper extremities consistently ☐ Communicate effectively

☐ Complete tasks on schedule ☐ Leave home

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Due to residual deficits, fatigue, or neurologic symptoms, the patient would be away from the work task (off-task and/or on unscheduled breaks) for approximately:

☐0% ☐10% ☐15% ☐20%+

Likely absences per month due to residual symptoms:

☐None ☐1 ☐2 ☐3+

SECTION 5 — SITTING, STANDING, AND WALKING TOLERANCE

Indicate the total time the 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

Need for assistive device:

☐ None ☐Cane ☐Walker ☐Wheelchair ☐Other: _____

Supporting findings (gait instability, fatigue-related decline, safety concerns): _____

SECTION 6 — UPPER EXTREMITY USE AND MANIPULATIVE RELIABILITY

Frequency of use limitations (if applicable):

ACTIVITY	NEVER (0%)	OCCASIONAL (≤1/3)	FREQUENT (1/3–2/3)	CONSTANT (2/3 - 100%)
HANDLING	☐	☐	☐	☐
FINGERING	☐	☐	☐	☐
REACHING	☐	☐	☐	☐

SECTION 7 — LIFTING, CARRYING, AND PHYSICAL ENDURANCE

WEIGHT	NEVER (0%)	OCCASIONAL (≤1/3)	FREQUENT (1/3–2/3)	CONSTANT (2/3 - 100%)
<10 LBS	☐	☐	☐	☐
10 LBS	☐	☐	☐	☐
20 LBS	☐	☐	☐	☐
50 LBS	☐	☐	☐	☐

Fatigue, weakness, or neurologic deficits significantly limit sustained exertion even at low levels? ☐Yes ☐No

SECTION 8 — CONSISTENCY

Do the limitations described above reflect what you have consistently observed and documented since the stroke, including longitudinal records and collateral reports?

☐ Yes ☐ No ☐ Partially (explain): _____

Provider Signature: _____ Date: _____

Address / Phone: _____