

PHYSICAL MEDICAL SOURCE STATEMENT

Re: _____(Name of Patient)

_____ (Date of Birth)

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

1. Frequency and length of contact: _____
2. Diagnoses: _____
3. Prognosis: _____
4. List your patient's *symptoms*, including pain, dizziness, fatigue, etc:

5. If your patient has pain, characterize the nature, location, frequency, precipitating factors, and severity of your patient's pain:

6. Identify the clinical findings and objective signs:

7. Describe the treatment and response including any side effects of medication that may have implications for working, *e.g.*, drowsiness, dizziness, nausea, etc.:

8. Have your patient's impairments lasted or can they be expected to last at least twelve months?
Yes No
9. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations?
Yes No

10. Identify any psychological conditions affecting your patient's physical condition:

Depression	Anxiety
Somatic symptom disorder	Personality disorder
Psychological factors affecting physical condition	Other: _____

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

a. How many city blocks can your patient walk without rest or severe pain? _____

b. Please circle the hours and/or minutes that your patient can sit **at one time**, e.g., before needing to get up, etc.

Sit:	<u>5 10 15 20 30 45</u>	<u>1 2 More than 2</u>
	Minutes	Hours

c. Please circle the hours and/or minutes that your patient can stand **at one time**, e.g., before needing to sit down, walk around, etc.

Stand:	<u>5 10 15 20 30 45</u>	<u>1 2 More than 2</u>
	Minutes	Hours

d. Please indicate how long your patient can sit and stand/walk **total in an 8-hour working day** (with normal breaks):

Sit	Stand/walk
less than 2 hours	less than 2 hours
about 2 hours	about 2 hours
about 4 hours	about 4 hours
at least 6 hours	at least 6 hours

e. Does your patient need a job that permits shifting positions at will from sitting, standing or walking? Yes No

f. Does your patient need to include periods of walking around during an 8-hour working day? Yes No

If yes, how often must your patient walk?	How long must your patient walk each time?
<u>1 5 10 15 20 30 45 60 90</u>	<u>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15</u>
Minutes	Minutes

g. In addition to normal breaks every two hours, will your patient sometimes need to take **unscheduled** breaks during a working day? Yes No

If yes, 1) approx. how **often** do you think this will happen? _____

2) approx. how **long** (on average) will each break last? _____

3) what symptoms cause a need for breaks?

If yes, please indicate the percentage of time during an 8-hour working day that your patient can use hands/fingers/arms for the following activities:

	HANDS: Grasp, Turn <u>Twist Objects</u>	FINGERS: Fine <u>Manipulations</u>	ARMS: Reaching <u>In Front of Body</u>	ARMS: Reaching <u>Overhead</u>
Right:	%	%	%	%
Left:	%	%	%	%

m. 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

n. To what degree can your patient tolerate work stress?

Incapable of even "low stress" work	Capable of low stress work
Capable of moderate stress - normal work	Capable of high stress work

Please explain the reasons for your conclusion: _____

o. Are your patient’s impairments likely to produce “good days” and “bad days”?

Yes No

If yes, assuming your patient was trying to work full time, please estimate, on the average, how many days per month your patient is likely to be absent from work as a result of the impairments:

Never	About three days per month
About one day per month	About four days per month
About two days per month	More than four days per month

12. Are your patient's impairments (physical impairments plus any emotional impairments) as demonstrated by signs, clinical findings and laboratory or test results ***reasonably consistent*** with the symptoms and functional limitations described above in this evaluation?

Yes No

If no, please explain: _____

13. Please describe any other limitations (such as psychological limitations, limited vision, difficulty hearing, need to avoid temperature extremes, wetness, humidity, noise, dust, fumes, gases or hazards, etc.) that would affect your patient's ability to work at a regular job on a sustained basis:

By signing this form, I agree that while these questions were provided by my patient's attorney, the form was delivered to my office not completed in any way, and my patient's attorney made no suggestions nor did he or she take any part in formulating the answers, responses, or opinions contained herein.

Date

Signature

Printed/Typed Name: _____

Address: _____
