MEDICAL SOURCE STATEMENT

CARDIOLOGY

Instructions/ Disclosure: This form is intended to be completed by a treating cardiologist or specialist for the listed patient. If you are unable to provide an answer to a question, please mark "N/A" or leave it blank. Please note this information will only be used in strict confidence for evaluation of the Patient's claim for disability by the Social Security Administration and will not be used in any other way. Thank you.

PATIENT INFORMATION

Last Name:	***First Name:***	***Date of Birth:***

PROVIDER & CLINIC INFORMATION

Provider Name:		***Area(s) of Practice:***
Clinic Name:		
Address:	***Office Number:***	***Fax Number:***
Date of Patient's First Exam:	***Date of Patient's Most Recent Exam:***	
Today's Date:		

Please complete the following questions based on your <u>professional judgement</u> regarding the patient's physical and cognitive limitations related to their diagnosed heart condition(s).

1. In the order of significance, please list any medical diagnoses the patient has received and how would characterize the severity of each?

2. Please cite any objective medical evidence confirming the diagnoses:

3. What treatment or medication has the patient undergone and what are the known or alleged side effects?

4. What is the patient's prognosis?

5. Describe the patient's symptoms, such as pain, dizziness, fatigue, etc.:

6. Does the patient have chronic pain/paresthesia? Yes ☐ No ☐

7. Please indicate all positive objective signs exhibited by the patient:

Angina	☐	Chest pain	☐	Dizziness	☐	Edema	☐	Fatigue	☐
Nausea	☐	Palpitations	☐	Shortness of breath	☐	Sweatiness	☐	Weakness	☐
Other:	☐	_____							

8. Please indicate any EXERTIONAL LIMITATIONS the patient has or is likely to experience due to their diagnosed medical condition(s):

Occasionally lift and/or carry, including upward pulling (maximum):

Less than 5 pounds	Less than 10 pounds	10-15 pounds	Up to 25 pounds	50 pounds or more
☐	☐	☐	☐	☐

Frequently lift and/or carry, including upward pulling (maximum):

Less than 5 pounds	Less than 10 pounds	10-15 pounds	Up to 25 pounds	50 pounds or more
☐	☐	☐	☐	☐

Stand and/or walk (with normal breaks) for a total of:

Less than 2 hours in an 8-hour workday	about 2-4 hours in an 8-hour workday	about 6 hours in an 8-hour workday	medically required hand-held assistive device is necessary for ambulation
☐	☐	☐	☐

Sit (with normal breaks) for a total of:

less than 2 hours in an 8-hour workday	about 6 hours in an 8-hour workday	must periodically alternate sitting and standing to relieve pain or discomfort (explain below)
☐	☐	☐

For any limitations indicated above, please elaborate further:

9. Does the patient suffer from significant fatigue or malaise that results in a substantial reduction of energy?

Yes ☐ **No** ☐

If YES, approx. how much physical energy do you believe the patient has for engaging in SEDENTARY or LIGHT level work activity over the course of an 8-hour workday:

	less than 2 hours	about 2-3 hours	about 4-5 hours	about 5-6 hours, with breaks	at least 6 hours
Sedentary*	☐	☐	☐	☐	☐
Light**	☐	☐	☐	☐	☐

NOTE:

Sedentary** level work means the ability to sit for up to 6 hours in an 8-hour day, and lift up to 10 lbs. occasionally during a day

****Light** level work means the ability to stand and walk for up to 6 hours in an 8-hour day, lift 10 lbs. frequently***** and 20 lbs. occasionally during a day

10. Please indicate any PHYSICAL FUNCTIONAL LIMITATIONS the patient has or is likely to experience due to their diagnosed medical condition(s):

	No Limitations	Frequently*	Occasionally**	Never
Climbing – ramps/stairs	☐	☐	☐	☐
Balancing	☐	☐	☐	☐
Stooping	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Crouching	☐	☐	☐	☐
Crawling	☐	☐	☐	☐
Fingering	☐	☐	☐	☐
Feeling	☐	☐	☐	☐
Handling	☐	☐	☐	☐
Reaching (including overhead)	☐	☐	☐	☐

NOTE:
*Frequently means the patient can perform the activity 2/3^{rds} of the time over the course of an 8-hour workday
**Occasionally means the patient can perform the activity 1/3rd of the time over the course of an 8-hour workday

For any limitations indicated, please elaborate further:

11. Please indicate any ENVIRONMENTAL LIMITATIONS the patient has or is likely to experience due to their diagnosed medical condition(s):

	Unlimited	Avoid concentrated exposure	Avoid even moderate exposure	Avoid all exposure
Extreme cold	☐	☐	☐	☐
Extreme heat	☐	☐	☐	☐
Wetness	☐	☐	☐	☐
Humidity	☐	☐	☐	☐
Noise	☐	☐	☐	☐
Vibration	☐	☐	☐	☐
Fumes, odors, dusts, gases, poor ventilation, etc.	☐	☐	☐	☐
Hazards (machinery, heights, etc.)	☐	☐	☐	☐

For any limitations indicated, please elaborate further:

12. Have these impairments lasted or are expected to last 12 consecutive months? Yes ☐ No ☐

The following questions relate to impairments or limitations in the patient's mental functioning due to their diagnosed medical condition(s) along with any side effects from medications or treatment. Refer to the following definitions in marking your responses:

Mild:	There are limitations on ability to function, but they are mild or transient.
Moderate:	The ability to function in this area is less than marked but more than mild.
Marked:	The ability to function in this area is seriously limited.
Extreme:	The ability to function in this area is precluded.
No Limitation:	There is no evidence available to rate the ability to function in this area.

13. Limitations concerning the patient's <u>Understanding and Memory</u> as related to their:

Ability to remember locations and work-like procedures:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to understand and remember new information (i.e., short term memory):

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to understand and remember detailed instructions:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

For any limitations indicated as **MARKED or EXTREME**, please elaborate further:

14. Limitations concerning the patient's <u>Sustained Concentration and Persistence</u> as related to their:

Ability to maintain attention and concentration for extended periods:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to maintain regular attendance at work on a full-time basis:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to sustain an ordinary routine without special supervision:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

For any limitations indicated as **MARKED or EXTREME**, please elaborate further:

15. Limitations concerning the patient's <u>Adaptability</u> as related to their:

Ability to respond appropriately and adapt to changes in the work setting:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to tolerate normal levels of stress:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to manage psychologically based symptoms (i.e., anxiety, depression, tearfulness):

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to work through and manage mental fatigue:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

For any limitations indicated as **MARKED or EXTREME**, please elaborate further:

16. Approximately what percent of time do you believe the patient would be "off task" over the course of an 8-hour day while performing work activity in a workplace?

10%	15%	20%	25%	Other
☐	☐	☐	☐	_____

17. Approximately how many days of work per month do you think the patient is likely to miss due to their medical conditions and treatment thereof? _____ days per month

18. Miscellaneous comments:

_____ _____

Provider's Name and Designation ***Provider's Specialty***

_____ _____

Provider Signature ***Date***

TO RETURN THIS REPORT

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PRIVACY ACT NOTICE: The information requested on this form will be used in deciding this patient's Social Security Disability Claim. Failure to complete this form may result in a delay in processing the claim. Information furnished on this form may be disclosed by the Social Security Administration to another person or governmental agency only with respect to Social Security programs and to comply with Federal laws requiring the exchange of information between Social Security and other agencies.