MEDICAL SOURCE STATEMENT

CROHN'S AND COLITIS

***Instructions/ Disclosure*:** This form is intended to be completed by a treating medical provider 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 opinion</u> regarding the patient's physical and cognitive limitations related to their diagnosed medical condition, symptoms, and side effects from medications and treatment.

1. **Frequency and length of contact: _____**

2. **Diagnoses:**

3. **Prognosis:**

4. **Identify your patient's symptoms:**

- ☐ Chronic diarrhea
- ☐ Bloody diarrhea
- ☐ Abdominal pain and cramping
- ☐ Fever
- ☐ Weight loss
- ☐ Loss of appetite
- ☐ Bowel obstruction
- ☐ Vomiting
- ☐ Abdominal distention
- ☐ Fistulas
- ☐ Anal fissures
- ☐ Nausea
- ☐ Peripheral arthritis
- ☐ Kidney problems
- ☐ Malaise
- ☐ Fatigue
- ☐ Mucus in stool
- ☐ Ineffective straining at stool
- ☐ (Rectal tenesmus)
- ☐ Sweatiness

☐ Other: _____

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

6. **If aspects of your patient's impairments are episodic, describe the nature, precipitating factors, severity, frequency, and duration of the episodic aspects:**

7. **Identify the clinical findings and objective signs:**

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

9. **Have your patient's impairments lasted, or can they be expected to last, at least twelve months?**

   Yes ☐ **No** ☐

10. **Do emotional factors contribute to the severity of your patient's symptoms and functional limitations?**

    Yes ☐ **No** ☐

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

    - ☐ Depression
    - ☐ Anxiety
    - ☐ Somatoform disorder
    - ☐ Personality disorder
    - ☐ Psychological factors affecting physical condition
    - ☐ Other:

12. **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 bocks can your patient walk? _____**

    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: 0 5 10 15 20 30 45 (Minutes) 1 2 More than 2 (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: 0 5 10 15 20 30 45 (Minutes) 1 2 More than 2 (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 a job that permits ready access to a restroom?

Yes ☐ **No** ☐

g. In addition to normal breaks every two hours, will your patient need to take unscheduled restroom 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) how much advance notice does your patient have of the need for a restroom break? _____

h. Will your patient also sometimes need to lie down or rest at unpredictable intervals during a working day? Yes ☐ **No** ☐

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

2) how long (on average) will your patient have to rest before returning to work? _____

3) what symptoms cause a need for such breaks? _____

PLEASE REFER TO THE FOLLOWING DEFINITIONS FOR THE FOLLOWING QUESTIONS:

Rarely: 1% to 5% of an 8-hour working day
Occasionally: 6% to 33% of an 8-hour working day
Frequently: 34% to 66% of an 8-hour working day

i. How many pounds can your patient lift and carry in a competitive work situation?

	Never	Rarely	Occasionally	Frequently
Less than 10 lbs.	☐	☐	☐	☐
10 lbs.	☐	☐	☐	☐
20 lbs.	☐	☐	☐	☐
50 lbs.	☐	☐	☐	☐

j. How often can your patient perform the following activities?

	Never	Rarely	Occasionally	Frequently
Twist	☐	☐	☐	☐
Stoop (bend)	☐	☐	☐	☐
Crouch/Squat	☐	☐	☐	☐
Climb ladders	☐	☐	☐	☐
Climb stairs	☐	☐	☐	☐

k. Does your patient have significant limitations with reaching, handling, or fingering? Yes ☐ No ☐

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 **Twist Objects**	FINGERS: Fine **Manipulations**	ARMS: Reaching **In Front of Body**	ARMS: Reaching **Overhead**
Right:	%	%	%	%
Left:	%	%	%	%

l. 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% ☐ 10% ☐ 20%
☐ 5% ☐ 15% ☐ 25% or more

m. 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:

n. 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 because of the impairments:

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

13. 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:

14. 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:

_____ _____

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

_____ _____

Provider Signature ***Date***

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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.*