MEDICAL SOURCE STATEMENT

DIABETES MELLITUS

***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:**

   ☐ Type 1 Diabetes Mellitus ☐ Type 2 DM ☐ Other

3. **Prognosis:**

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

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

   Yes ☐ No ☐

6. Identify your patient's symptoms:

- ☐ Fatigue
- ☐ Difficulty walking
- ☐ Episodic vision blurriness
- ☐ Bladder infections
- ☐ Bed wetting
- ☐ Infections/fevers
- ☐ Excessive thirst
- ☐ Rapid heartbeat/chest pain
- ☐ Swelling
- ☐ Chronic skin infections
- ☐ Sensitivity to light, heat or cold
- ☐ General malaise
- ☐ Muscle weakness
- ☐ Retinopathy
- ☐ Kidney problems
- ☐ Hot flashes
- ☐ Psychological problems
- ☐ Abdominal pain
- ☐ Vascular disease/leg cramping
- ☐ Insulin shock/coma
- ☐ Nausea/vomiting
- ☐ Extremity pain and numbness
- ☐ Loss of manual dexterity
- ☐ Diarrhea
- ☐ Frequency of urination
- ☐ Sweating
- ☐ Difficulty concentrating
- ☐ Headaches
- ☐ Dizziness/loss of balance
- ☐ Hypoglycemia
- ☐ Hypoglycemia unawareness
- ☐ Other: _____

7. Clinical findings:

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

Yes ☐ No ☐

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

- ☐ Depression
- ☐ Anxiety
- ☐ Somatic symptom disorder
- ☐ Personality disorder
- ☐ Other: _____

10. As a result of your patient's impairments, estimate your patient's functional limitations if your patient were paced 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: 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 include period of walking around during an 8-hour working day?

Yes ☐ No ☐

If ***yes,*** how **often** must your patient walk?

0 5 10 15 20 30 45 60 90

Minutes

How **long** must your patient walk each time?

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15

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?

- ☐ Muscle weakness
- ☐ Chronic fatigue
- ☐ Pain/paresthesia's, numbness
- ☐ Adverse effects of medication
- ☐ Other: _____

h. With prolonged sitting, should our patient's leg(s) be elevated?

Yes ☐ No ☐

If yes, 1) how high should the leg(s) be elevated? _____

2) if your patient had a sedentary job, what percentage of time during an 8-hour working day should the legs be elevated? _____%

3) what symptoms cause a need to elevate leg(s)? _____

i. While engaging in occasional standing/walking, must your patient use a cane or other assistive device?

Yes ☐ No ☐

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

j. 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.	☐	☐	☐	☐

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

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

l. If your patient has significant limitations with reaching, handling, or fingering, 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:	%	%	%	%

m. State the degree to which your patient should avoid the following:

Environmental Restrictions	No Restrictions	Avoid Concentrated Exposure	Avoid Even Moderate Exposure	Avoid All Exposure
Extreme cold	☐	☐	☐	☐
Extreme heat	☐	☐	☐	☐
High humidity	☐	☐	☐	☐
Wetness	☐	☐	☐	☐
Cigarette smoke	☐	☐	☐	☐
Perfumes	☐	☐	☐	☐
Soldering fluxes	☐	☐	☐	☐
Solvents/cleaners	☐	☐	☐	☐
Fumes, odors, gases	☐	☐	☐	☐
Dust	☐	☐	☐	☐
Chemicals	☐	☐	☐	☐

List other irritants: _____

n. 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

o. To what degree can your patient tolerate work stress

☐ Incapable of even "low stress" work
☐ Capable of moderate stress – normal work
☐ Capable of low stress work
☐ Capable of high stress work

Please explain the reasons for your conclusion:

p. 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

11. 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 in this evaluation?

Yes	No
☐	☐

If no, please explain: _____

12. Please describe any other limitations (such as psychological limitations, limited vision, difficulty hearing, 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***

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.*