MEDICAL SOURCE STATEMENT

GASTROENTEROLOGY

***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 professional judgement regarding the patient's physical and cognitive limitations related to their diagnosed medical condition(s).

1. When did you first treat the patient and how often do you treat the patient now?

2. What are the patient's diagnosed digestive disorder(s) and how would you characterize the severity of each the diagnoses? (Please indicate MILD, MODERATE, or SEVERE)

3. Are these diagnoses substantiated by medically acceptable clinical and laboratory techniques?

4. What are the symptoms that the patient experiences due to their digestive disorder(s)?

5. What treatment has the patient undergone to treat these digestive disorder(s) and what is the current prognosis of each?

6. In your opinion, how much pain does patient experience due to patient's digestive disorder(s) on a scale of 1-10? (1 = low, 10 = high)

7. How frequent does the patient require use of a toilet throughout the day and how long does the patient use the toilet for on average?

8. Has the patient undergone any drastic weight gain or weight loss while under your care?

9. If yes to 8, has the patient had a BMI of less than 17.50 calculated on at least two evaluations at least 60 days apart within a consecutive 6-month period? If yes, please provide the dates of the evaluations and the patient's BMI on each of those dates.

10. Does the patient suffer from fatigue that results in a substantial reduction of energy? If so, what diagnosed medical condition(s) accounts for the patient's fatigue?

11. Does the patient have malaise that results in a substantial reduction of energy? If so, what diagnosed medical condition(s) accounts for the patient's malaise?

12. Does the patient have obstruction of stenotic areas (not adhesions) in the small intestine or colon with proximal dilatation confirmed by appropriate medically acceptable imaging or in surgery?

13. Has the patient's obstruction of stenotic areas (not adhesions) in the small intestine or colon occurred on at least two occasions at least 60 days apart within a consecutive 6-month period?

14. Does the patient suffer from severe abdominal pain?

15. Has the patient described any changes in their bowel habits or complain of bloody stools?

16. EXERTIONAL LIMITATIONS DUE TO GASTROINTESTINAL DISORDER

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

less than 10 pounds	10 pounds	25 pounds	50 pounds	100 pounds or more
☐	☐	☐	☐	☐

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

less than 10 pounds	10 pounds	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)
☐	☐	☐

Push and/or pull (including operation of hand and/or foot controls):

unlimited, other than as shown for lift and/or carry	limited in upper extremities (describe nature and degree)	limited in lower extremities (describe nature and degree)
☐	☐	☐

Please explain how and why the evidence supports your conclusions concerning the exertional limitations indicated above. Cite the specific facts upon which your conclusions are based.

16. Are you aware of any activities of daily living that the patient has difficulties doing because of their diagnosed medical conditions or from side-effects of their prescribed medication? [Activities of daily living include bathing; dressing; simple household chores; driving; etc.]

17. 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 environment? This includes the need for necessary bathroom breaks.

10%	15%	20%	25%	Other
☐	☐	☐	☐	_____

18. How often would the patient need to miss work each month because of their medical condition(s) or for treatment thereof?

_____ days per month

19. In your medical opinion, do you think the patient can work a full-time job reliably?

_____ _____

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

_____ _____

Provider Signature ***Date***

TO RETURN THIS REPORT

Email :
medical@desertdisability.com

Mail :
Desert Disability PLC
7272 E. Indian School Rd. Suite 540
Scottsdale, AZ 85251

Fax :
480-420-8720

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.