MEDICAL SOURCE STATEMENT

BILATERAL HAND FUNCTION

Instructions/ Disclosure: This form is intended to be completed by a medical professional that specializes in orthopedic hand treatment or is treating a medical condition of the patient that involves the patient's hands. If a question does not apply to the patient or cannot be answered, please write "N/A" or leave blank. Please provide any additional information in any of the comments sections as may be appropriate.

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 answer the following questions based on your <u>professional judgement</u> regarding the patient's medical condition(s).

1. What are the patient's physical diagnoses and what is the level of severity of each?

2. Does the patient have reduced capacity that affects the patient's arms and hands? Yes ☐ No ☐

If yes, which upper extremities are affected and how severe are the limitations?

4. In your opinion, what is the patient's prognosis concerning their condition(s)?

5. Have the patient's physical impairments lasted or is expected to last 12 consecutive months? Yes ☐ No ☐

6. Which is the patient's dominant hand? RIGHT-HAND ☐ LEFT-HAND ☐

7. Please indicate the patient's symptoms with each of their hands:

	Pain	Weakness	Paresthesia	Sensory Loss	Cramping	Spasms
Right Hand	☐	☐	☐	☐	☐	☐
Left Hand	☐	☐	☐	☐	☐	☐

8. Please indicate the patient's manipulative limitations with each of their hands:

	No Limitations		**Frequently***		**Occasionally****		**Never**	
	Right	Left	Right	Left	Right	Left	Right	Left
Fingering	☐	☐	☐	☐	☐	☐	☐	☐
Feeling	☐	☐	☐	☐	☐	☐	☐	☐
Handling	☐	☐	☐	☐	☐	☐	☐	☐
Keyboard Usage	☐	☐	☐	☐	☐	☐	☐	☐
Fine Manipulation	☐	☐	☐	☐	☐	☐	☐	☐

*__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 symptoms or limitations indicated in Q7 or Q8, please elaborate further:

9. Please indicate the patient's upper extremity muscle strength from 1 to 5:
Muscle strength shown on chart below is rated on scale of 1 to 5 with 1 being significantly weak and 5 being normal.

	Right UE	Left UE
Biceps		
Triceps		
Wrist Flexion		
Wrist Extension		
Finger Abduction		
Hand Grip		

For any limitations indicated above, please elaborate further:

10. 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
☐	☐	☐	☐	☐

Overhead reaching (the ability to reach above shoulder level):

No Reaching	Occasional Reaching	Frequent Reaching	No Limitations
☐	☐	☐	☐

Computer usage (with normal breaks) for a total of:

Never	less than 2 hours in an 8-hour workday	Between 2-4 hours in an 8-hour workday	Between 4-6 hours in an 8-hour workday	No Limitations
☐	☐	☐	☐	☐

For any limitations indicated above, please elaborate further:

11. Miscellaneous comments:

_____ _____

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

_____ _____

Provider Signature *Date*

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.*

TO RETURN THIS REPORT

Electronic preferred

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