MEDICAL SOURCE STATEMENT

LIVER DISEASE

***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.

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. 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 is the current prognosis?

4. What symptoms does the patient experience and what are the side effects of treatment/medication?

5. Does the Patient's diagnosis/diagnoses result in portal hypertension, cholestasis, extrahepatic manifestations, or liver cancer? If so, please explain?

6. Have the patient's impairments lasted or are expected to last 12 consecutive months?

YES: ☐ **NO:** ☐

7. Please indicate any SYMPTOMS AND SIGNS the patient has or is likely to experience:

	None	Mild	Moderate	Severe
Hemorrhaging	☐	☐	☐	☐
Pruritis (itching)	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐
Nausea	☐	☐	☐	☐
Loss of Appetite	☐	☐	☐	☐
Sleep Disturbances	☐	☐	☐	☐
Jaundice	☐	☐	☐	☐
Enlargment of the liver and spleen	☐	☐	☐	☐
Ascites	☐	☐	☐	☐
Peripheral edema	☐	☐	☐	☐
Altered mental state	☐	☐	☐	☐

For any **MODERATE or SEVERE** limitations indicated above, please elaborate further:

8. Does the patient have diagnosed chronic liver disease with ascites or hydrothorax not attributable to other causes, despite continuing treatment as prescribed, present on at least 2 evaluations at least 60 days apart within a consecutive 6-month period?

YES: ☐ **NO:** ☐

a) If **YES**, were the evaluations documented by paracentesis or thoracentesis? **YES:** ☐ **NO:** ☐

b) If **YES**, were the evaluations documented by appropriate medically acceptable imaging or physical examination and a Serum Albumin reading of 3.0 g/dL or less? **YES:** ☐ **NO:** ☐

c) If **YES**, were the evaluations documented by appropriate medically acceptable imaging or physical examination and an International Normalized Ratio (INR) of at least 1.5? **YES:** ☐ **NO:** ☐

9. Does the patient have diagnosed chronic liver disease with hemorrhaging from esophageal, gastric, or ectopic varices or from portal hypertensive gastropathy, demonstrated by endoscopy, x-ray, or other appropriate medically acceptable imaging, resulting in hemodynamic instability, and requiring hospitalization for transfusion of at least 2 units of blood?

YES: ☐ **NO:** ☐

10. Please list the dates and volume of blood (in units) of any blood transfusions the patient has required due to gastrointestinal hemorrhaging:

11. Does the patient have diagnosed chronic liver disease with spontaneous bacterial peritonitis with peritoneal fluid containing an absolute neutrophil count of at least 250 cells/mm3?

YES: ☐ **NO:** ☐

12. Does the patient have diagnosed chronic liver disease with hepatorenal syndrome? YES: ☐ **NO:** ☐

a) If **YES**, has there been a serum creatinine elevation of at least 2 mg/dL? **YES:** ☐ **NO:** ☐

b) If **YES**, has there been oliguria with 24-hour urine output less than 500 mL? **YES:** ☐ **NO:** ☐

c) If **YES**, has there been sodium retention with urine sodium less than 10 mEq per liter? **YES:** ☐ **NO:** ☐

13. Does the patient have diagnosed chronic liver disease with hepatopulmonary syndrome? YES: ☐ **NO:** ☐

a) If **YES**, has there been arterial oxygenation (PaO2) on room air of 60 mm Hg or less, at test sites less than 3000 feet above sea level?

YES: ☐ **NO:** ☐

b) If **YES**, has there been arterial oxygenation (PaO2) on room air of 55 mm Hg or less, at test sites from 3000 to 6000 feet?

YES: ☐ **NO:** ☐

c) If **YES**, has there been arterial oxygenation (PaO2) on room air of 50 mm Hg or less, at test sites above 6000 feet?

YES: ☐ **NO:** ☐

14. Does the patient have diagnosed chronic liver disease with hepatopulmonary syndrome and documentation of intrapulmonary arteriovenous shunting by contrast-enhanced echocardiography or macroaggregated albumin lung perfusion scan?

YES: ☐ **NO:** ☐

15. Does the patient have diagnosed chronic liver disease with hepatic encephalopathy and documentation of abnormal behavior, cognitive dysfunction, changes in mental status, or altered state of consciousness (for example, confusion, delirium, stupor, or coma), present on at least two evaluations at least 60 days apart within a consecutive 6-month period?

YES: ☐ **NO:** ☐

a) If **YES**, has there been a history of transjugular intrahepatic portosystemic shunt (TIPS) or any surgical portosystemic shunt?

YES: ☐ **NO:** ☐

b) If **YES**, has there been asterixis or other fluctuating physical neurological abnormalities that have occurred on at least two evaluations at least 60 days apart?

YES: ☐ **NO:** ☐

c) If **YES**, has there been electroencephalogram (EEG) demonstrating triphasic slow wave activity that have occurred on at least two evaluations at least 60 days apart?

YES: ☐ **NO:** ☐

d) If **YES**, is there lab work showing a reading of serum albumin of 3.0 g/dL or less that occurred on at least two evaluations at least 60 days apart?

YES: ☐ **NO:** ☐

e) If **YES**, is there lab work showing a reading of International Normalized Ratio (INR) of 1.5 or greater that occurred on at least two evaluations at least 60 days apart?

YES: ☐ **NO:** ☐

16. Does the patient have end stage liver disease with SSA CLD scores of 22 or greater? YES: ☐ **NO:** ☐

For any responses marked YES to questions 8-16, please elaborate further:

17. Does the patient have diagnosed Inflammatory Bowel Disease (IBD) documented by endoscopy, biopsy, appropriate medically acceptable imaging, or operative findings with obstruction of stenotic areas (not adhesions) in the small intestine or colon with proximal dilatation, confirmed by appropriate medically acceptable imaging or in surgery, requiring hospitalization for intestinal decompression or for surgery, and occurring on at least two occasions at least 60 days apart within a consecutive 6-month period?

YES: ☐ **NO:** ☐

18. Has the patient had two (2) of the following despite continuing treatment as prescribed and occurring within the same consecutive 6-month period:

a) Anemia with hemoglobin of less than 10.0 g/dL, present on at least two evaluations at least 60 days apart?

YES: ☐ **NO:** ☐

b) Serum albumin of 3.0 g/dL or less, present on at least two evaluations at least 60 days apart?

YES: ☐ **NO:** ☐

c) Clinically documented tender abdominal mass palpable on physical examination with abdominal pain or cramping that is not completely controlled by prescribed narcotic medication?

YES: ☐ **NO:** ☐

d) Perineal disease with a draining abscess or fistula, with pain that is not completely controlled by prescribed narcotic medication?

YES: ☐ **NO:** ☐

e) Involuntary weight loss of at least 10 percent from baseline, as computed in pounds, kilograms, or BMI, present on at least two evaluations?

YES: ☐ **NO:** ☐

f) Need for supplemental daily enteral nutrition via a gastrostomy or daily parenteral nutrition via a central venous catheter?

YES: ☐ **NO:** ☐

For any responses marked YES to questions 17-18, please elaborate further:

19. Does the patient have short bowel syndrome (SBS) due to surgical resection of more than one-half of the small intestine, with dependence on daily parenteral nutrition via a central venous catheter?

YES: ☐ **NO:** ☐

If YES, pleas elaborate further:

20. Does the patient have weight loss due to any digestive disorder despite continuing treatment as prescribed, with BMI of less than 17.50 calculated on at least two evaluations at least 60 days apart within a consecutive 6-month period?

YES: ☐ **NO:** ☐

If YES, pleas elaborate further:

21. 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:

22. Does the Patient suffer from fatigue or malaise that results in a substantial reduction of energy?

YES: ☐ **NO:** ☐

If YES, what diagnosed medical condition(s) accounts for the patient's fatigue or malaise?

If YES to Question 22, approximately 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[1]	☐	☐	☐	☐	☐
Light[2]	☐	☐	☐	☐	☐

[1] **Sedentary level** work means the ability to sit for up to 6 hours in an 8-hour day and lift to 10 lbs. occasionally* during a day.
*Occasionally means 1/3rd of the time over the course of an 8-hour work period.

[2] **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.
**Frequently means 2/3rds of the time over the course of an 8-hour work period.

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

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

*Occasionally means 1/3rd of the time over the course of an 8-hour period
**Frequently means 2/3rds of the time over the course of an 8-hour period

For any physical and postural limitations indicated above, please elaborate further:

24. 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
☐	☐	☐	☐	_____

25. 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

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.*