MEDICAL SOURCE STATEMENT
NEUROLOGICAL DISORDERS

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 INFORMATION

Provider Name:		***Area 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 neurological impairment, and any side effects from medications and treatment.

1. In the order of significance, please list any medical diagnoses the patient has received and how you 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 are the known or alleged side effects?

4. What is the patient's current prognosis?

5. Does the patient have any limitations or impairments affecting their UPPER or LOWER extremities? If so, please describe:

6. Does the patient experience headaches? If so, please indicate the type and severity:

HEADACHE TYPE		**LEVEL OF SEVERITY**		
MIGRAINE ☐	CHRONIC ☐	MILD ☐	MODERATE ☐	SEVERE ☐

If YES to Q6, please identify the source of the patient's headaches (if known):

7. Does the patient experience seizures or seizure-like activity? If so, please describe the patient's seizures further:

If YES to Q7, what is the known or suspected source of the patient's seizures?

8. Does the patient experience persistent auras or "brain fog"? If so, how frequent are these episodes and how long do they typically last?

9. Does the patient have significant cognitive decline from a prior level of functioning in any of the following cognitive areas?

Complex Attention	Executive Function	Learning & Memory	Language	Perceptual-Motor	Social Cognition
☐	☐	☐	☐	☐	☐

For any areas of significant cognitive decline identified 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
☐	☐	☐	☐	☐

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 in Q10, please elaborate further:

11. Please indicate any PHYSICAL/POSTURAL FUNCTIONAL LIMITATIONS the patient has or is likely to experience due to their diagnosed medical condition(s):

	No Limitations	**Frequently[1]**	**Occasionally[2]**	**Never**
Climbing – ramps/stairs	☐	☐	☐	☐
Balancing	☐	☐	☐	☐
Stooping	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Crouching	☐	☐	☐	☐
Crawling	☐	☐	☐	☐
Fingering	☐	☐	☐	☐
Feeling	☐	☐	☐	☐
Handling	☐	☐	☐	☐
Reaching (including overhead)	☐	☐	☐	☐

For any limitations indicated, please elaborate further:

12. Please indicate any ENVIRONMENTAL LIMITATIONS the patient has or is likely to experience due to their diagnosed medical condition(s):

	Unlimited	**Avoid concentrated exposure**	**Avoid even moderate exposure**	**Avoid all exposure**
Extreme cold	☐	☐	☐	☐

[1] Frequently means the patient can perform the activity 2/3^{rds} of the time over the course of an 8-hour workday

[2] Occasionally means the patient can perform the activity 1/3rd of the time over the course of an 8-hour workday

Extreme heat	☐	☐	☐	☐
Wetness	☐	☐	☐	☐
Humidity	☐	☐	☐	☐
Noise	☐	☐	☐	☐
Vibration	☐	☐	☐	☐
Fumes, odors, dusts, gases	☐	☐	☐	☐
Hazards (machinery, heights, etc.)	☐	☐	☐	☐

For any limitations indicated, please elaborate further:

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

If YES to Question 13, 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*	☐	☐	☐	☐	☐
Light**	☐	☐	☐	☐	☐

NOTE:
Sedentary** level work means the ability to sit for up to 6 hours in an 8-hour day, and lift up to 10 lbs. occasionally during a day
****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
*****Occasionally** means 1/3rd of the time over the course of an 8-hour work period
******Frequently** means 2/3rds of the time over the course of an 8-hour work period

14. Does the patient have any impairments that affect their vision or hearing? If so, please describe in detail:

Questions 15-17 relate to impairments or limitations in the patient's cognitive functioning due to their diagnosed neurological condition(s) along with any side effects from treatment. Refer to the following definitions in marking your responses:

Mild:	There are limitations on ability to function, but they are mild or transient.
Moderate:	The ability to function in this area is less than marked but more than mild.
Marked:	The ability to function in this area is seriously limited.
Extreme:	The ability to function in this area is precluded.
No Limitation:	There is no evidence available to rate the ability to function in this area.

15. Limitations concerning the patient's <u>Understanding and Memory</u> as related to their:

Ability to remember locations and work-like procedures:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to understand and remember new information (i.e., short term memory):

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to understand and remember detailed instructions:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

For any limitations indicated as **MARKED or EXTREME**, please elaborate further:

16. Limitations concerning the patient's <u>Sustained Concentration and Persistence</u> as related to their:

Ability to maintain attention and concentration for extended periods:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to maintain regular attendance at work on a full-time basis:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to sustain an ordinary routine without special supervision:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

For any limitations indicated as **MARKED or EXTREME**, please elaborate further:

17. Limitations concerning the patient's <u>Adaptability</u> as related to their:

Ability to respond appropriately and adapt to changes in the work setting:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to tolerate normal levels of stress:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to manage psychologically based symptoms (i.e., anxiety, depression, tearfulness):

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to work through and manage mental fatigue:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

For any limitations indicated as **MARKED or EXTREME**, please elaborate further:

18. Approximately what percent of time do you believe the patient would be "off task" over the course of an 8-hour workday?

10%	15%	20%	25%	Other
☐	☐	☐	☐	_____

19. 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

20. Have these impairments lasted or are expected to last 12 consecutive months? Yes ☐ No ☐

21. Miscellaneous 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.*