MEDICAL SOURCE STATEMENT

PHYSICAL

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 judgement</u> 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 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 prognosis?

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

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

7. 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:

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

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

For any limitations indicated above, please elaborate further:

9. 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	☐	☐	☐	☐
Extreme heat	☐	☐	☐	☐
Wetness	☐	☐	☐	☐
Humidity	☐	☐	☐	☐
Noise	☐	☐	☐	☐
Vibration	☐	☐	☐	☐
Fumes, odors, dusts, gases, poor ventilation, etc.	☐	☐	☐	☐
Hazards (machinery, heights, etc.)	☐	☐	☐	☐

For any limitations indicated above, please elaborate further:

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?

If YES to Questions 10 or 11, 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 2/3^{rds} of the time over the course of an 8-hour work period.

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

14. 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
☐	☐	☐	☐	_____

15. 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

In your opinion, do you believe the patient can work a job on a full-time basis at this time?

_____ _____

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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