# MEDICAL SOURCE STATEMENT

## PULMONARY

***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, symptoms, and side effects from medications and treatment. Attach relevant treatment notes, radiologist reports, laboratory, and test results as appropriate.**

1. **Frequency and length of contact: _____**

2. **Diagnoses:**

3. **Please cite any objective medical evidence confirming the diagnoses:**

4. **Identify all your patient's symptoms:**

- ☐ Shortness of breath
- ☐ Orthopnea
- ☐ Chest tightness
- ☐ Wheezing
- ☐ Rhonchi
- ☐ Edema
- ☐ Other symptoms: _____
- ☐ Episodic acute bronchitis
- ☐ Episodic pneumonia
- ☐ Episodic acute asthma
- ☐ Palpitations
- ☐ Coughing
- ☐ Fatigue

**5. If your patient has acute asthma attacks:**

a. Identify the precipitating factors:

- ☐ Upper respiratory infection
- ☐ Allergens
- ☐ Exercise
- ☐ Aspirin
- ☐ Tartrazine
- ☐ Emotional upset/stress
- ☐ Irritants
- ☐ Cold air/change in weather
- ☐ Foods

b. Characterize the nature and severity of your patient's attacks:

c. How often does your patient have asthma attacks?

d. How long is your patient incapacitated during an average attack?

**6. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations?**

**Yes** ☐ **No** ☐

If no, please explain:

**7. Please list your patient's prescribed medications:**

**8. Please describe any side effects of your patient's medications (particularly of steroids, if applicable) that may have implications for working, e.g., dizziness, fatigue, drowsiness, stomach upset, etc.:**

**9. What is your patient's prognosis?**

**10. Have your patient's impairments lasted, or can they be expected to last, at least 12 months? Yes** ☐ **No** ☐

**11. As a results of your patient's impairments, estimate your patient's functional limitations if your patient were placed in a *competitive work situation:***

a. How many city blocks can your patient walk without rest or severe pain? _____

b. Please circle the hours and/or minutes that your patient can **sit *at one time***, e.g., before needing to get up, etc.

*0 min. 5 min. 10 min. 15 min. 20 min. 30 min. 45 min. 1 hour 2 hours 2+ hours*

c. Please circle the hours and/or minutes that your patient can **stand *at one time***, e.g., before needing to sit down, walk around, etc.

*0 min. 5 min. 10 min. 15 min. 20 min. 30 min. 45 min. 1 hour 2 hours 2+ hours*

d. How long can your patient sit and stand/walk total **in an 8-hour working day** (with normal breaks)?

| **Sit** | **Stand/Walk** |
|---|---|
| ☐ Less than 2 hours | ☐ Less than 2 hours |
| ☐ About 2 hours | ☐ About 2 hours |
| ☐ About 4 hours | ☐ About 4 hours |
| ☐ At least 6 hours | ☐ At least 6 hours |

e. In addition to normal breaks every two hours, will your patient sometimes need to take unscheduled breaks during a working day? **Yes** ☐ **No** ☐

If yes, 1) approx. how ***often*** do you think this will happen? _____

2) approx. how ***long*** (on average) will each break last? _____

3) on such a break, will your patient need to lie down or sit quietly? _____

**PLEASE REFER TO THE FOLLOWING DEFINITIONS FOR THE FOLLOWING QUESTIONS:**

**Rarely:** **1% to 5% of an 8-hour working day**
**Occasionally:** **6% to 33% of an 8-hour working day**
**Frequently:** **34% to 66% of an 8-hour working day**

f. How many pounds can your patient lift and carry in a competitive work situation?

| | Never | Rarely | Occasionally | Frequently |
|---|---|---|---|---|
| Less than 10 lbs. | ☐ | ☐ | ☐ | ☐ |
| 10 lbs. | ☐ | ☐ | ☐ | ☐ |
| 20 lbs. | ☐ | ☐ | ☐ | ☐ |
| 50 lbs. | ☐ | ☐ | ☐ | ☐ |

g. How often can your patient perform the following activities?

| | Never | Rarely | Occasionally | Frequently |
|---|---|---|---|---|
| Twist | ☐ | ☐ | ☐ | ☐ |
| Stoop (bend) | ☐ | ☐ | ☐ | ☐ |
| Crouch/Squat | ☐ | ☐ | ☐ | ☐ |
| Climb ladders | ☐ | ☐ | ☐ | ☐ |
| Climb stairs | ☐ | ☐ | ☐ | ☐ |

h. State the degree to which your patient should avoid the following:

| | 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.) | ☐ | ☐ | ☐ | ☐ |

i. How much is your patient likely to be ***"off-task"***? That is, what percentage of a typical workday would your patient's symptoms likely be severe enough to interfere with ***attention and concentration*** needed to perform even simply work tasks?

☐ 0%
☐ 5%
☐ 10%
☐ 15%
☐ 20%
☐ 25% or more

j. To what degree can your patient tolerate work stress?

☐ Incapable of even "low stress" work
☐ Capable of moderate stress – normal work
☐ Capable of low stress work
☐ Capable of high stress work

Please explain the reasons for your conclusion: _____

k. Are your patient's impairments likely to produce "good days" and "bad days"? **Yes** ☐ **No** ☐

If yes, assuming your patient was trying to work full time, please estimate, on average, how many days per month your patient is likely to be absent from work because of the impairments:

- ☐ Never
- ☐ About one day per month
- ☐ About two days per month
- ☐ About three days per month
- ☐ About four days per month
- ☐ More than four days per month

**12. Are your patient's impairments (physical impairments plus any emotional impairments) as demonstrated by signs, clinical findings, and laboratory or test results *reasonably consistent* with the symptoms and functional limitations described above in this evaluation?**

**Yes** ☐ **No** ☐

If no, please explain:

**13. Please describe any other limitations (such as psychological limitations, limited vision, difficulty hearing, need to avoid temperature extremes, wetness, humidity, noise, dust, fumes, gases, or hazards, etc.) that would affect your patient's ability to work at a regular job on a sustained basis:**

_____ _____

***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.*