MEDICAL SOURCE STATEMENT
RESPIRATORY

***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(s).

1. When did you first see the patient and how often do you see them now?

2. In the order of significance, please list any medical diagnoses the patient has received and how would characterize the severity of each?

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

4. What are the patient's respiratory disorders or pulmonary conditions (in order of significance) and what is the level of severity of each? [Please indicate if MILD, MODERATE, or SEVERE]

5. Has the patient had a Spirometry Test, DLCO Test or an ABG Test? If so, what was the date of the last test for each and what results were out of normal range?

6. What is the patient's forced expiratory volume in one second (FEV1) and forced vital capacity (FVC) measurements over the past 24-months?

7. What are the symptoms that the patient experiences due to their respiratory disorders or pulmonary conditions?

8. What medication(s) or oxygen device(s) have been prescribed for treating the patient's respiratory disorders or pulmonary conditions? Please also describe any known side effects.

9. Does the patient's respiratory disorders or conditions affect their fatigue and energy level? If so, please describe how, and what activities should be avoided.

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 10 pounds	10 pounds	25 pounds	50 pounds	100 pounds or more
☐	☐	☐	☐	☐

Frequently lift and/or carry, including upward pulling (maximum):

less than 10 pounds	10 pounds	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	at least 2 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 about 6 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)
☐	☐	☐

Push and/or pull (including operation of hand and/or foot controls):

unlimited, other than as shown for lift and/or carry	limited in upper extremities (describe nature and degree)	limited in lower extremities (describe nature and degree)
☐	☐	☐

Explain how and why the evidence supports your conclusions concerning the exertional limitations indicated above:

11. POSTURAL LIMITATIONS

☐ None established. (Proceed to the next section)	**Frequently****	**Occasionally***	**Never**
Climbing	☐	☐	☐
Balancing	☐	☐	☐
Stooping	☐	☐	☐
Kneeling	☐	☐	☐
Crouching	☐	☐	☐
Crawling	☐	☐	☐

NOTE:
*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.

For any limitations indicated, please elaborate further:

12. ENVIRONMENTAL LIMITATIONS

☐ None established. (Proceed to the next section)				
	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.)	☐	☐	☐	☐

Describe how these environmental factors impair activities and identify hazards to be avoided. Also, explain how and why the evidence supports your conclusions.

13. 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 environment?

10%	15%	20%	25%	Other
☐	☐	☐	☐	_____

14. How often would the patient need to miss work each month because of the patient's medical condition(s) or for treatment thereof?

_____ days per month

15. In your medical opinion, do you think the patient could maintain full-time employment at this time?

_____ _____

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.