MEDICAL SOURCE STATEMENT
RHEUMATOLOGY

Instructions/ Disclosure: This residual functional capacity assessment 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 opinion</u> regarding the patient's physical and cognitive limitations related to their diagnosed medical condition, symptoms, and side effects from medications and treatment.

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

2. What is the medical impairment (rheumatoid arthritis, traumatic arthritis, osteoarthritis, etc.) causing joint dysfunction, and what is the level of severity of each?
(Please indicate whether it is MILD, MODERATE, or SEVERE for each impairment)

3. Is there a history of chronic joint pain and stiffness? If so, when did the patient first complain to you of such symptoms?

5. In the affected joints, is there significant limitation of motion?

6. Does the patient have difficulty ambulating or use any ambulatory devices?

7. In your opinion, what level of pain from 1-10 does the patient experience daily? Does the patient's pain cause any physical or cognitive limitations?

8. What prescribed medication(s) is/are the patient taking and what are the known side effects of those medication(s)?

9. Does the patient have radiculopathy or nerve impingement? If so, please describe the nature of the nerve impingement and which extremity(ies) is/are affected.

10. Does the patient have gross anatomical deformity of any joint?

A. Hands/Wrist	**One Hand**	**Both Hands**
☐ Ulnar deviation	☐	☐
☐ Swan-neck deformity	☐	☐
☐ Boutonniere deformity	☐	☐
☐ Contracture	☐	☐
☐ Bony or fibrious ankylosis	☐	☐
☐ Instability	☐	☐
☐ Other (please specify)		

B. Elbows	**Left**	**Right**
☐ Contracture	☐	☐
☐ Bony or fibrious ankylosis	☐	☐
☐ Instability	☐	☐
☐ Other (please specify)		

C. Shoulders	**Left**	**Right**
☐ Contracture	☐	☐
☐ Bony or fibrious ankylosis	☐	☐
☐ Instability	☐	☐
☐ Other (please specify)		

D. Hips	Left	Right
☐ Contracture	☐	☐
☐ Bony or fibrious ankylosis	☐	☐
☐ Instability	☐	☐
☐ Other (please specify)		

E. Knees	Left	Right
☐ Contracture	☐	☐
☐ Bony or fibrious ankylosis	☐	☐
☐ Instability	☐	☐
☐ Other (please specify)		

F. Ankles	Left	Right
☐ Contracture	☐	☐
☐ Bony or fibrious ankylosis	☐	☐
☐ Instability	☐	☐
☐ Other (please specify)		

Please describe any imaging exams that have been performed that substantiate your responses to A-F:

11. The patient's current lower extremity functional limitations:

	Yes	No	Unknown
A. Can the patient ambulate without the use of a hand-held assistive device that limits the functioning of both upper extremities?	☐	☐	☐
B. Can the patient sustain a reasonable walking pace over a sufficient distance to be able to carry out activities of daily living?	☐	☐	☐
C. Is the patient able to walk one block at a reaosnable pace on rough or uneven surfaces?	☐	☐	☐

12. The patient's current upper extremity functional limitations:

	Yes	No	Unknown
A. Does the patient have an extreme loss of function in both upper extremities, to the extent that the ability to perform fine and gross movements seriously interferes with the ability to independently initiate, sustain, or complete activities?	☐	☐	☐
B. Is the patient able to sort and handle paper or files?	☐	☐	☐
C. Is the patient able to place files in a file cabinet at or above waist level?	☐	☐	☐
D. Is the patient able to use a computer keyboard for extended periods of time?	☐	☐	☐

13. Exertional Limitations

Please respond based on the maximum capacity the patient can comfortably perform these exertional activities:

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	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 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. Cite the specific facts upon which your conclusions are based.

14. Postural Limitations

Please respond based on the maximum capacity the patient can comfortably perform these exertional activities:

NOTE:
***Occasionally** means very little up to 1/3 of an 8-hour workday.
****Frequently** means 1/3 to 2/3 of an 8-hour workday.

☐ None established. (Proceed to the next section)	**Frequently**	**Occasionally**	**Never**
Climbing – ramp/stairs	☐	☐	☐
Climbing – ladder/rope/scaffolds	☐	☐	☐
Balancing	☐	☐	☐
Stooping	☐	☐	☐
Kneeling	☐	☐	☐
Crouching	☐	☐	☐
Crawling	☐	☐	☐

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

15. Manipulative Limitations

☐ None established. (Proceed to the next section)	**Limited**	**Unlimited**
Reaching all directions (including overhead)	☐	☐
Handling (gross manipulation)	☐	☐
Fingering (fine manipulation)	☐	☐
Feeling (skin receptors)	☐	☐

Please describe how the activities checked "limited" are impaired and cite the specific facts upon which your conclusions are based:

16. Visual Limitations

☐ None established. (Proceed to the next section)	**Limited**	**Unlimited**
Near acuity	☐	☐
Far acuity	☐	☐
Depth perception	☐	☐
Accommodation	☐	☐
Color vision	☐	☐
Field of vision	☐	☐

Describe how the faculties checked "limited" are impaired.

17. Communicative Limitations

☐ None established. (Proceed to the next section)	**Limited**	**Unlimited**
Hearing	☐	☐
Speaking	☐	☐

Describe how the faculties checked "limited" are impaired. Also, explain how and why the evidence supports your conclusions concerning any communicative limitations:

18. 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.

19. 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
☐	☐	☐	☐	_____

20. Approximately how often would the patient need to miss work each month because of their medical condition(s) or for treatment thereof?

_____ days per month

21. Do you think the patient could maintain full-time employment at this time?

22. Miscellaneous comments:

_____ _____

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

MAIL:	EMAIL:	FAX:
Desert Disability PLC 7272 E. Indian School Rd. Suite 540 Scottsdale, AZ 85251	medical@desertdisability.com	(480) 420-8720