MEDICAL SOURCE STATEMENT

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 the evaluation of the patient's claim for disability benefits and will not be used in any other way. Thank you.

Patient Name: _____ **DOB:** _____ **Date of First Exam:** _____

Provider Name: _____ **Date of Last Exam:** _____

Please complete the following questions based on your professional judgment of the patient's physical and cognitive limitations related to their diagnosed medical condition(s).

1. In the order of significance, list any medical diagnoses the patient has received and characterize the **severity** of each:

2. Please cite any **objective medical evidence** confirming the diagnoses (i.e., bloodwork, MRIs, etc.):

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. Does the patient have any limitations that affect the patient's **ability to lift and carry** objects?
If yes, please describe in detail:

7. Does the patient have any limitations that affect the patient's **ability to stand or walk** for extended periods?
If yes, please describe in detail:

8. Does the patient have any limitations that affect the patient's **ability to sit** for extended periods?
If yes, please describe in detail:

9. Does the patient have any limitations that affect the patient's **ability for gross or fine manipulation** using their hands?
If yes, please describe in detail:

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

11. Does the patient have any impairments that affect their **cognitive abilities**? If so, please describe in detail:

12. Approximately what percent of time do you believe the patient would be **"off task"** over the course of an 8-hour workday due to their medical condition(s)?

10%	15%	20%	25%	Other
☐	☐	☐	☐	_____

13. 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

14. Have these impairments lasted or are expected to last **12 consecutive months**? Yes: _____ No: _____

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

Additional comments and notes:

_____ _____

Provider's Name and Designation ***Provider's Specialty***

_____ _____

Provider Signature ***Today's Date***

TO RETURN THIS REPORT

Email :
medical@desertdisability.com

Mail :
Desert Disability PLC
7272 E. Indian School Rd. Suite 540
Scottsdale, AZ 85251

Fax :
480-420-8720

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.*