MEDICAL SOURCE STATEMENT

SPINAL NERVE ROOT COMPRESSION

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 comment on whether your patient has the following impairment:

Disorders of the spine (e.g., herniated nucleus pulposus, spinal arachnoiditis, spinal stenosis, osteoarthritis, degenerative disc disease, facet arthritis, vertebral fracture), resulting in compromise of a nerve root (including the caudal equina) or the spinal cord. With:

A. Evidence of nerve root compression characterized by neuro-anatomic distribution of pain, limitation of motion of the spine, motor loss (atrophy with associated muscle weakness or muscle weakness) accompanied by sensory or reflex loss and, if there is involvement of the lower back, positive straight-leg raising text (sitting and supine).

1. **Does your patient have a disorder of the spine? Yes ☐ No ☐**

   If yes, please identify the disorder: _____

2. **Does your patient have evidence of nerve root compression? Yes ☐ No ☐**

3. **Does your patient have neuro-anatomic distribution of pain? Yes ☐ No ☐**

   If *yes,* please describe:

4. **Does your patient have any limitation of motion of the spine? Yes ☐ No ☐**

   If yes, indicate range of motion with the following movements:

   Flexion _____ ° Lateral Bending – Right _____ °

   Extension _____ ° Lateral Bending – Left _____ °

5. **Does your patient have any muscle weakness? Yes ☐ No ☐**

If yes, please identify the affected muscles and describe using the grading system 0 to 5:

6. Identify any positive signs of motor loss:

- ☐ Inability to walk on heels
- ☐ Inability to walk on toes
- ☐ Inability to squat
- ☐ Inability to arise from squatting position
- ☐ Atrophy: Indicate circumferential measurements of both thighs and lower legs or upper and lower arms as appropriate:

_____

_____

7. Does your patient have sensory *or* reflex loss? Yes ☐ No ☐

If *yes*, please describe:

8. Is there involvement of the lower back? Yes ☐ No ☐

If *yes*, does your patient have a positive straight leg raising test *both* sitting and supine? **Yes ☐ No ☐**

Please describe:

9. If the clinical findings do not match *all* the findings required above, are your patient's combined impairments medically *equivalent* to the severity of the conditions in the listed impairment? **Yes ☐ No ☐**

If *yes*, please explain in detail how your patient's impairments are equivalent to the impairment listed above, with reference to **specific supporting clinical findings:**

_____ _____

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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