MEDICAL SOURCE STATEMENT

STROKE

***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. Has your patient had a stroke/CVA? Yes ☐ No ☐ Date of Stroke: _____

2. If yes, what type of stroke? _____

3. List any other diagnoses: _____

4. Identify your patient's symptoms and signs:

Balance problems ☐	Other sensory disturbance ☐	Confusion ☐
Poor coordination ☐	Pain ☐	Depression ☐
Loss of manual dexterity ☐	Fatigue ☐	Emotional lability ☐
Weakness ☐	Bladder problems ☐	Personality change ☐
Slight paralysis ☐	Nausea ☐	Difficulty solving problems ☐
Unstable walking ☐	Vertigo/dizziness ☐	Problems with judgment ☐
Falling spells ☐	Headaches ☐	Double or blurred vision ☐
Numbness or tingling ☐	Difficulty remembering ☐	Partial or complete blindness ☐
Shaking tremor ☐	Speech/communication difficulties ☐	

5. Indicate any other symptoms and clinical findings:

6. Do emotional factors contribute to the severity of your patient's functional limitations? Yes ☐ No ☐

7. Treatment and response:

8. Prognosis:

9. Have the patient's impairments lasted or are expected to last 12 consecutive months? **Yes** ☐ **No** ☐

10. As a result 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? _____

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

Sit: 0 5 10 15 20 30 45 (**MINUTES**) 1 2 More than 2 (**HOURS**)

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

Sit: 0 5 10 15 20 30 45 (**MINUTES**) 1 2 More than 2 (**HOURS**)

d. Does your patient need a job that permits shifting positions at will from sitting, standing, or walking?

Yes ☐ **No** ☐

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) approximately how ***often*** do you think a break will be needed? _____

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

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

f. With prolonged sitting, should your patient's legs be elevated? **Yes** ☐ **No** ☐

If yes: 1) how ***high*** should the legs be elevated? _____

2) if your patient had a sedentary (sit down) job, what percentage of time during an 8-hour working day should their legs be elevated? _____%

g. While engaging in occasional standing/walking, must your patient use a cane or other assistive device?

Yes ☐ **No** ☐

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**

11. Please indicate any PHYSICAL FUNCTIONAL 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 5 pounds	Less than 10 pounds	10-15 pounds	Up to 25 pounds	50 pounds or more
☐	☐	☐	☐	☐

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

Less than 5 pounds	Less than 10 pounds	10-15 pounds	Up to 25 pounds	50 pounds or more
☐	☐	☐	☐	☐

If no limitations, leave blank	Can frequently:	Can occasionally:	Can rarely:	Can never:
Climbing – ramps/stairs	☐	☐	☐	☐
Balancing	☐	☐	☐	☐
Stooping	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Crouching	☐	☐	☐	☐
Crawling	☐	☐	☐	☐
Fingering	☐	☐	☐	☐
Feeling	☐	☐	☐	☐
Handling	☐	☐	☐	☐
Reaching (including overhead)	☐	☐	☐	☐
Computer keyboard usage	☐	☐	☐	☐

12. Does your patient have significant limitations with reaching, handling, or fingering? Yes ☐ No ☐

13. Indicate 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.)	☐	☐	☐	☐

14. Does the Patient suffer from fatigue or malaise that results in a substantial reduction of energy? YES ☐ NO ☐

15. If YES to Question 14, approximately how much physical energy do you believe your patient has for engaging in SEDENTARY or LIGHT level work activity over the course of an 8-hour workday:

	less than 2 hours	about 2-3 hours	about 4-5 hours	about 5-6 hours, with breaks	at least 6 hours
Sedentary[1]	☐	☐	☐	☐	☐
Light[2]	☐	☐	☐	☐	☐

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

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

Please explain the reasons for your conclusion:

The following questions relate to impairments or limitations in the Patient's mental functioning due to their diagnosed medical condition(s) along with any side effects from medications or treatment. Refer to the following definitions in marking your responses:

Mild:	There are limitations on ability to function, but they are mild or transient.
Moderate:	The ability to function in this area is less than marked but more than mild.
Marked:	The ability to function in this area is seriously limited.
Extreme:	The ability to function in this area is precluded.
No Limitation:	There is no evidence available to rate the ability to function in this area.

17. Limitations concerning the patient's <u>Understanding and Memory</u> as related to their:

Ability to remember locations and work-like procedures:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to understand and remember new information (i.e., short term memory):

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to understand and remember detailed instructions:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

[1] **Sedentary level** work means the ability to sit for up to 6 hours in an 8-hour day and lift to 10 lbs. occasionally* during a day.
*Occasionally means 1/3rd of the time over the course of an 8-hour work period.

[2] **Light level** work means the ability to stand and walk for up to 6 hours in an 8-hour day, lift 10 lbs. frequently** and 20 lbs. occasionally during a day.
**Frequently means 2/3rds of the time over the course of an 8-hour work period.

For any limitations indicated as **MARKED or EXTREME**, please explain the reasons for your conclusion

18. Limitations concerning the patient's <u>Sustained Concentration and Persistence</u> as related to their:

Ability to maintain attention and concentration for extended periods:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to maintain regular attendance at work on a full-time basis:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to sustain an ordinary routine without special supervision:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

For any limitations indicated as **MARKED or EXTREME**, please explain the reasons for your conclusion:

19. Limitations concerning the patient's <u>Adaptability</u> as related to their:

Ability to respond appropriately and adapt to changes in the work setting:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to manage psychologically based symptoms (i.e., anxiety, depression, tearfulness):

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to work through and manage mental fatigue:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

For any limitations indicated as **MARKED or EXTREME**, please explain the reasons for your conclusion

20. 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?

5%	10%	15%	20%	25%	Other
☐	☐	☐	☐	☐	_____ %

21. 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

Miscellaneous comments:

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

TO RETURN THIS REPORT

Email :	Mail :	Fax :
medical@desertdisability.com	Desert Disability PLC 7272 E. Indian School Rd. Suite 540 Scottsdale, AZ 85251	(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.*