MEDICAL SOURCE STATEMENT
VESTIBULAR DISORDER

***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 answer the following questions concerning your patient's vestibular disorder and other health problems based on your professional opinion. *Attach all relevant treatment notes, laboratory and test results which have not been provided previously to the Social Security Administration.*

1. **Date began treatment:** _____
2. **Frequency of treatment:** _____
3. **Does your patient have Meniere's Disease? YES ☐ NO ☐**
4. **Other Diagnoses:**

5. **Does your patient have:**

   a.) History of frequent attacks of balance disturbance? YES ☐ NO ☐

   b.) Tinnitus? YES ☐ NO ☐

   c.) Progressive hearing loss? YES ☐ NO ☐

If yes, is the hearing loss established by audiometry? YES ☐ NO ☐

If no, explain how the hearing loss was established:

6. **Would your patient likely exhibit difficulty understanding oral communications in the presence of constant background machinery noise or similar work environments? YES ☐ NO ☐**

7. **Is disturbed function of vestibular labyrinth demonstrated by caloric or other vestibular tests? YES ☐ NO ☐**

If no, explain how the absence of vestibular tests or a negative vestibular test affects the diagnosis and assessment of severity of the impairment:

8. **Identify symptoms associated with your patient's Meniere's attacks:**

- ☐ Vomiting/Nausea
- ☐ Malaise
- ☐ Vertigo
- ☐ Visual Disturbances
- ☐ Photosensitivity
- ☐ Mood Changes
- ☐ Sensitivity to Noise
- ☐ Fatigue/Exhaustion
- ☐ Mental Confusion/Inability to Concentrate
- ☐ Other: _____

9. **What is the average frequency of your patient's Meniere's attacks?**

_____ per week _____ per month

10. **How long does a typical attack last?** _____

11. **Does your patient always have a warning of an impending attack? YES ☐ NO ☐**

If yes, how long is it between the warning and the onset of the attack? _____ minutes

12. **Can your patient always take safety precautions when he/she feels an attack coming on? YES ☐ NO ☐**

13. **Are there precipitating factors such as stress, exertion, sudden movement, certain kinds of light, computer monitors, etc.?**
YES ☐ NO ☐

If yes, explain:

14. **If your patient exhibits positional vertigo, identify the postures or positions which are likely to cause vertigo:**

- ☐ Sitting to standing
- ☐ Bending forward at the waist
- ☐ Walking
- ☐ Turning head to left/right
- ☐ Looking up
- ☐ Looking down
- ☐ Other: _____

15. What are post-attack manifestations?

- ☐ Confusion
- ☐ Severe Headache
- ☐ Exhaustion
- ☐ Paranoia
- ☐ Irritability
- ☐ Other: _____

How long after an attack do these manifestations last? _____

16. Does your patient experience symptoms which interfere with the *attention and concentration* needed to perform even simple work tasks, so that if your patient was working s/he would likely be *"off task" at least 15%* of the time?

YES ☐ **NO** ☐

17. If your patient was placed in a competitive job, identify those aspects of workplace stress that your patient would be unable to perform or be exposed to:

- ☐ Routine, repetitive tasks at consistent pace
- ☐ Detailed or complicated tasks
- ☐ Frequent interaction with coworkers/supervisors/public
- ☐ Fast paced tasks (e.g., production line)
- ☐ Exposure to work hazards (e.g., heights or moving machinery

18. Identify any side effects of any medications which may have implications for working:

- ☐ Drowsiness
- ☐ Other: _____

19. As a result of your patient's impairment(s), estimate your patient's functional limitations, assuming your patient was placed in a competitive work situation on an ongoing basis:

a.) How many city blocks can the patient **walk** without rest or severe pain? _____

b.) Please circle the hours and/or minutes that your patient can *continuously* **sit and stand** *at one time:*

Sit:	0 min.	5 min.	10 min.	15 min.	20 min.	30 min.	45 min.	1 hour	2 hours	2+ hours
Stand:	0 min.	5 min.	10 min.	15 min.	20 min.	30 min.	45 min.	1 hour	2 hours	2+ hours

What must your patient usually do after **sitting** this long?

- ☐ Walk
- ☐ Stand
- ☐ Lie down
- ☐ Other: _____

What must your patient usually do after **standing** this long?

- ☐ Walk
- ☐ Sit
- ☐ Lie down
- ☐ Other: _____

20. Please indicate how long your patient can sit and stand/walk *total in an eight-hour workday* (with normal breaks)?

Sit	**Stand/Walk**
☐ Less than 2 hours	☐ Less than 2 hours
☐ About 2 hours	☐ About 2 hours
☐ About 4 hours	☐ About 4 hours
☐ At least 6 hours	☐ At least 6 hours

21. Due to your patient's impairment(s), if your patient will sometimes need to take unscheduled *breaks* (for at least several minutes duration) during an average eight-hour workday, *how many times* during an average workday do you expect this to happen? (Please circle a number)

1 2 3 4 5 6 7 8 9 10 10+

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

YES ☐ **NO** ☐

23. How many pounds can the patient lift and carry in a competitive work situation?

	Never	Rarely	Occasionally	Frequently
Less than 10 lbs.	☐	☐	☐	☐
10 lbs.	☐	☐	☐	☐
20 lbs.	☐	☐	☐	☐
50 lbs.	☐	☐	☐	☐

24. How often can your patient perform the following waist level activities?

	Never	Rarely	Occasionally	Frequently
Twist	☐	☐	☐	☐
Stoop (bend)	☐	☐	☐	☐

25. If your patient's symptoms cause significant limitations with reaching, handling, or fingering, please estimate the percentage of time during an eight-hour workday that your patient can use hands/fingers/arms for the following activities:

HANDS: GRASP, TURN Twist Objects	**FINGERS**: FINE Manipulations	**ARMS**: REACHING Incline Overhead
Right _____%	*Right* _____%	*Right* _____%
Left _____%	*Left* _____%	*Left* _____%

26. Imagine that your patient was hired to perform competitive full-time work. Please estimate, on average, how often your patient would experience "bad days" so that your patient would be absent from work because of the impairment(s) or treatment:

- ☐ Never/*less than once* a month
- ☐ About *once or twice* a month
- ☐ About *three* days a month
- ☐ About *four days* a month
- ☐ *More than four days* a month

I understand your patient exhibits a vestibular disorder, not a seizure disorder. However, Social Security describes a seizure disorder that they consider disabling. This description follows:

11.03

Epilepsy – Minor motor seizures (petit mal, psychomotor, or focal), occurring more frequently than once weekly, despite at least 3 months of prescribed treatment, with alteration of transient postictal manifestations of unconventional behavior or significant interference with activity during the day.

27. In your opinion, is your patient's vestibular disorder, in combination with any other impairment(s), at least as medically severe as the condition described above?

YES ☐ **NO** ☐

If yes, please explain:

_____ _____

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

_____ _____

Provider Signature ***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.*