MEDICAL SOURCE STATEMENT

VISION IMPAIRMENT

Instructions/ Disclosure: This form is intended to be completed by an optometrist, ophthalmologist, or other vision specialist that treats the patient for an eye condition or has otherwise performed an eye test on the patient. If a question does not apply to the patient or cannot be answered, please write "N/A" or leave blank. Please provide any additional information in any of the comments sections as may be appropriate.

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 vision impairments and attach any vision exams and treatment notes related to the patient.

1. **What diagnoses has the patient received?**

2. **What exam(s) have been administered on the patient and what are the date(s)?**

3. **Please describe the patient's vision symptoms:**

4. **Have these impairments lasted or are expected to last 12 consecutive months? Yes ☐ No ☐**

5. **What is the patient's prognosis?**

6. **Patient's visual acuity after best correction in the RIGHT eye:**

7. Patient's visual acuity after best correction in the LEFT eye:

8. Patient's visual acuity after best correction in the RIGHT eye:

9. Patient's visual acuity after best correction in the LEFT eye:

10. Please describe any contraction of peripheral visual fields of the patient:

11. Does the patient have disturbance of labyrinthine-vestibular function? Yes ☐ No ☐

If YES, please describe:

12. Please indicate any FUNCTIONAL LIMITATIONS the patient has or is likely to experience due to the impairment in patient's vision and associated symptoms:

	No Limitations	Frequently*	Occasionally**	Never
Walking	☐	☐	☐	☐
Climbing Stairs	☐	☐	☐	☐
Balancing	☐	☐	☐	☐
Reading	☐	☐	☐	☐
Computer Usage	☐	☐	☐	☐
Commercial Driving	☐	☐	☐	☐
Working With Small Parts	☐	☐	☐	☐

*Frequently means the patient can perform the activity 2/3^{rds} of the time over the course of an 8-hour workday
**Occasionally means the patient can perform the activity 1/3rd of the time over the course of an 8-hour workday

13. Please indicate any EXERTIONAL 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
☐	☐	☐	☐	☐

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 periodically alternate sitting and standing to relieve pain or discomfort (explain below)
☐	☐	☐

14. 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?

10%	15%	20%	25%	Other
☐	☐	☐	☐	_____

15. 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

16. 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:
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