AMYOTROPHIC LATERAL SCLEROSIS (ALS) – MEDICAL SOURCE STATEMENT

Re: _____(Name of Patient)

_____(Date of Birth)

Please answer the following questions concerning your patient's impairments. ***Attach relevant treatment notes, radiologist reports, laboratory and test results as appropriate.***

1. Frequency and length of contact: _____
2. Does your patient suffer from Amytrophic Lateral Sclerosis (ALS)? ☐ Yes ☐ No
3. Please specify the findings on examination, neurologic and diagnostic testing that support a diagnosis of ALS:

   _____

4. Identify your patient's symptoms and signs:

   ☐ Muscle weakness
   ☐ Muscle fatigue
   ☐ Difficulty gripping, grasping and holding objects
   ☐ Muscle atrophy
   ☐ Impaired gait
   ☐ Muscle wasting
   ☐ Speech problems
   ☐ Impaired control of distal musculature
   ☐ Impaired ability to perform rapid successive movements
   ☐ Trouble swallowing
   ☐ Falls
   ☐ Postural instability
   ☐ Muscle cramps
   ☐ Limited UE range of motion
   ☐ Muscle twitching
   ☐ Impaired ability to rise from sitting
   ☐ Impaired endurance and stamina
   ☐ Muscle aches

   Other symptoms, signs and clinical findings:

   _____

5. If your patient has **muscle weakness/fatigue**, please describe the severity and the parts of the body affected:

   _____

6. Please describe treatment and response:

   _____

   _____

7. Prognosis: _____

8. Have your patient's impairments lasted or can they be expected to last at least twelve months? ☐ Yes ☐ No
9. Identify any associated psychological problems/ limitations:

   ☐ Cognitive limitations
   ☐ Impaired attention and concentration
   ☐ Impaired short term memory
   ☐ Sleep disturbance
   ☐ Reduced ability to persist in tasks
   ☐ Impaired fine/gross motor function
   ☐ Depression
   ☐ Social withdrawal
   ☐ Anxiety
   ☐ Reduced energy and stamina
   ☐ Other: _____

10. Identify **side effects** of any medications or treatment for ALS that may have implications for working:
    ☐ Drowsiness/ sedation ☐ Other: _____

11. 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 or severe pain? _____
    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 ***at one time***, *e.g.*, before needing to sit down, walk around, *etc*.

       Stand: ☐0 ☐5 ☐10 ☐15 ☐20 ☐30 ☐45 Minutes ☐1 ☐2 ☐More than 2 Hours

    d. Please indicate how long your patient can sit and stand/walk ***total in an 8-hour working day*** (with normal breaks):

Sit	Stand/walk	
☐	☐	less than 2 hours
☐	☐	about 2 hours
☐	☐	about 4 hours
☐	☐	at least 6 hours

e. Does your patient need to include periods of walking around during an 8-hour working day?
☐ Yes ☐ No

If yes, how ***often*** must your patient walk?

☐1 ☐5 ☐10 ☐15 ☐20 ☐30 ☐45 ☐60 ☐90
Minutes

How ***long*** must your patient walk each time?

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
Minutes

f. Does your patient need a job that permits shifting positions at will from sitting, standing or walking?
☐ Yes ☐ No

g. Will your patient sometimes need to take unscheduled breaks during a working day? ☐ Yes ☐ No

If yes, 1) how ***often*** do you think this will happen? _____
2) how ***long*** (on average) will your patient have to rest before returning to work? _____
3) what symptoms cause a need for breaks?
☐ Muscular aches ☐ Tremor enhanced by stress
☐ Chronic fatigue ☐ Adverse effects of medication
☐ Other: _____

h. With prolonged sitting, should your patient's leg(s) be elevated? ☐ Yes ☐ No

If yes, 1) how *high* should the leg(s) be elevated? _____
2) if your patient had a sedentary job*, what percentage of time* during an 8 hour working day should the leg(s) be elevated? _____%
3) what symptoms cause a need to elevate the leg(s)?
_____

i. While engaging in occasional standing/walking, must your patient use a cane or other assistive device?
☐ Yes ☐ No

If yes, what symptoms cause the need for a cane?
☐ Imbalance ☐ Fatigue ☐ Muscle weakness/fatigue
☐ Insecurity ☐ Impaired muscle control
☐ Other: _____
_____

"Rarely" means 1% to 5% of an 8-hour working day; "occasionally" means 6% to 33% of an 8-hour working day; "frequently" means 34% to 66% of an 8-hour working day.

j. How many pounds can your patient lift and carry in a competitive work situation?

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

k. How often can your patient perform the following activities?

	Never	**Rarely**	**Occasionally**	**Frequently**
Twist	☐	☐	☐	☐
Stoop (bend)	☐	☐	☐	☐
Crouch	☐	☐	☐	☐
Climb ladders	☐	☐	☐	☐
Climb stairs	☐	☐	☐	☐

l. If your patient has significant limitations with reaching, handling or fingering:
What symptoms cause limitations of use of the upper extremities?
☐ Muscle weakness ☐ Muscle twitching ☐ Impaired muscle control
☐ Muscle fatigue ☐ Muscle cramps
☐ Muscle aches/pain ☐ Decreased range of motion of upper extremities
☐ Other: _____

Please indicate the percentage of time during an 8-hour working day that your patient can use hands/fingers/arms for the following activities:

	HANDS: Grasp, Turn, Twist Objects	**FINGERS**: Fine Manipulations	**ARMS**: Reaching (incl. Overhead)
Right:	___%	___%	___%
Left:	___%	___%	___%

m. How often during a typical workday is your patient's experience of symptoms severe enough to interfere with ***attention and concentration*** needed to perform even simple work tasks?

☐ **Never** ☐ **Rarely** ☐ **Occasionally** ☐ **Frequently** ☐ **Constantly**

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

☐ Incapable of even "low stress" jobs
☐ Moderate stress is okay
☐ Capable of low stress jobs
☐ Capable of high stress jobs

Please explain the reasons for your conclusion:

_____
_____

o. Are your patient's impairments likely to produce "good days" and "bad days"? ☐ Yes ☐ No

If yes, please estimate, on the average, how many days per month your patient is likely to be absent from work as a result of the impairments or treatment:

☐ Never
☐ About one day per month
☐ About two days per month
☐ About three days per month
☐ About four days per month
☐ More than four days per month

12. Are your patient's impairments (physical impairments plus any emotional impairments) as demonstrated by signs, clinical findings and laboratory or test results *reasonably consistent* with the symptoms and functional limitations described above in this evaluation? ☐ Yes ☐ No
If no, please explain:

_____
_____

13. Please describe any additional limitations (such as limited vision, difficulty hearing, difficulty speaking, need to avoid temperature extremes, wetness, humidity, noise, dust, fumes, gases or hazards, etc.) that would impair your patient's ability to work at a regular job on a sustained basis:

_____
_____
_____

14. What is the **earliest date** that the description of symptoms and limitations in this form applies? _____

_____ _____
Physician's Signature ***Date form completed***

Printed/Typed Name: _____

Address: _____

_____

_____