INFLAMMATORY ARTHRITIS MEDICAL SOURCE STATEMENT

From: _____

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. Is your patient diagnosed with psoriatic arthritis (PsA)?
   Which of the following is your diagnosis based on?
   - ☐ (1) the presence of psoriasis (current, history of, or family history of),
   - ☐ (2) psoriatic nail dystrophy,
   - ☐ (3) a negative RF test result,
   - ☐ (4) dactylitis (history of or current), and
   - ☐ (5) radiographic evidence of juxta-articular new bone formation.
   - ☐ (6) Other:

3. Other diagnoses: _____

   _____

4. Identify any clinical findings, laboratory and test results, symptoms and positive objective signs of your patient's impairment (or adverse effects of treatments):

☐ Erosive arthritis involving pain in two or more peripheral joints. ***Note if affected joints also exhibit:*** ☐ tenderness ☐ swelling ☐ effusion ☐ deformity	Identify affected joints: _____ _____ _____

Constitutional Symptoms

	☐	Severe fatigue	☐	Fever
	☐	Involuntary weight loss	☐	Malaise

List any other signs or symptoms:_____

_____

_____

5. **FUNCTIONAL LIMITATIONS**

Limitation of activities of daily living	None or Mild ☐	Moderate ☐	Marked ☐
Limitation in maintaining social functioning	None or Mild ☐	Moderate ☐	Marked ☐
Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence or pace	None or Mild ☐	Moderate ☐	Marked ☐

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

7. Identify prescribed medications and treatments and the side effects of any medication (particularly of steroids and DMARDS, if applicable) that may have implications for working, e.g., dizziness, drowsiness, stomach upset, cataracts, liver damage, etc.:

8. Prognosis: _____

9. Have your patient's impairments lasted or can they be expected to last at least 12 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 ***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 a job that permits shifting positions ***at will*** from sitting, standing or walking? ☐ Yes ☐ No

f. 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) on such a break, will your patient need to ☐ lie down or ☐ sit quietly?

g. While engaging in occasional standing/walking, must your patient use a cane or other assistive device? ☐ Yes ☐ NoFor this and other questions on this form, “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.

h. 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.	☐	☐	☐	☐

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

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

j. If your patient has significant limitations with reaching, handling or fingering, 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 In Front of Body**	**ARMS: Reaching Overhead**
Right:	**%**	**%**	**%**	**%**
Left:	**%**	**%**	**%**	**%**

k. State the degree to which your patient should avoid the following:

ENVIRONMENTAL RESTRICTIONS	**NO RESTRICTIONS**	**AVOID CONCENTRATED EXPOSURE**	**AVOID EVEN MODERATE EXPOSURE**	**AVOID ALL EXPOSURE**
Extreme cold	☐	☐	☐	☐
Extreme heat	☐	☐	☐	☐
High humidity	☐	☐	☐	☐
Wetness	☐	☐	☐	☐
Cigarette smoke	☐	☐	☐	☐
Perfumes	☐	☐	☐	☐

Soldering fluxes	☐	☐	☐	☐
Solvents/cleaners	☐	☐	☐	☐
Fumes, odors, gases	☐	☐	☐	☐
Dust	☐	☐	☐	☐
Chemicals	☐	☐	☐	☐
List other irritants:	☐	☐	☐	☐

l. How much is your patient likely to be **"*off task*"**? That is, what percentage of a typical workday would your patient's symptoms likely be severe enough to interfere with ***attention and concentration*** needed to perform even simple work tasks?

☐ 0% ☐ 5% ☐ 10% ☐ 15% ☐ 20% ☐ 25% or more

m. 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: _____

n. Are your patient's impairments likely to produce "good days" and "bad days"?

☐ Yes ☐ No

If yes, assuming your patient was trying to work full time, 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

11. 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 other limitations (such as psychological limitations, limited vision, difficulty hearing, etc.) that would affect your patient's ability to work at a regular job on a sustained basis:

_____

_____ _____

Date *Signature*

Printed/Typed Name: _____

Address: _____

_____