NEUROLOGY/ORTHOPEDIC MEDICAL SOURCE STATEMENT

From: ________________________________

Re: ________________________________ (Name of Patient)

________________________________ (Date of Birth)

Please answer the following questions concerning your patient's impairments. Please attach relevant treatment notes, radiologist reports, and laboratory and test results if you have not already done so.

A. GENERAL INFORMATION

1. Frequency and length of contact:

2. Diagnoses:

3. Prognosis:

4. Identify all of your patient's ***symptoms***, including pain, dizziness, fatigue, etc.:

5. Have your patient's impairments lasted or can they be expected to last at least twelve months? ☐ Yes ☐ No

B. NEUROLOGICAL IMPAIRMENTS

1. Does your patient have peripheral neuropathy? ☐ Yes ☐ No

2. Identify your patient's clinical signs and symptoms:

☐ Pain
☐ Paresthesias
☐ Abnormal gait
☐ Deficiencies in joint proprioception
☐ Diminished stamina
☐ Decreased energy
☐ Postural hypotension
☐ Weakness
☐ Sensory loss
☐ Decreased deep tendon reflexes
☐ Chronic fatigue
☐ Lower extremity swelling
☐ Cramping, burning calves & feet
☐ Muscle atrophy

Other clinical findings:

3. If your patient has pain and paresthesias, characterize the severity of the pain and paresthesias:

☐ Mild ☐ Moderate ☐ Severe

Describe location, frequency, duration and precipitating factors of your patient's pain and paresthesias:

C. ORTHOPEDIC IMPAIRMENTS

1. If your patient has orthopedic pain, characterize the nature, location, frequency, precipitating factors and severity of your patient's pain and other symptoms:

2. Identify any positive objective clinical signs present on examination:

- ☐ Reduced range of motion - Joints affected: ____________________ ____________________
- ☐ Joint warmth
- ☐ Joint deformity
- ☐ Joint instability
- ☐ Myofascial trigger points
- ☐ Radicular symptoms
- ☐ Sensory changes
- ☐ Reflex changes
- ☐ Impaired sleep
- ☐ Weight change
- ☐ Impaired appetite
- ☐ Abnormal posture
- ☐ Tenderness
- ☐ Crepitus
- ☐ Reduced grip strength
- ☐ Redness
- ☐ Swelling
- ☐ Muscle spasm
- ☐ Muscle weakness
- ☐ Muscle atrophy
- ☐ Abnormal gait
- ☐ Positive straight leg raising test

Other clinical findings:

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

4. Identify any associated psychological problems/ limitations:

- ☐ Cognitive limitations
- ☐ Impaired attention and concentration
- ☐ Impaired short term memory
- ☐ Reduced ability to attend to tasks
- ☐ Reduced ability to persist in tasks
- ☐ Personality change
- ☐ Depression
- ☐ Social withdrawal
- ☐ Anxiety
- ☐ List others below:

5. Describe the treatment and response including any side effects of medication that may have implications for working, *e.g.*, drowsiness, dizziness, nausea:

D. FUNCTIONAL LIMITATIONS

1. As a result of your patient's impairments, please estimate what your patient's functional limitations would be 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 before needing to get up, change positions, 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, rest, 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. Does your patient need to include periods of walking around during an 8-hour working day? ☐ Yes ☐ No

1) If yes, approximately how ***often*** must your patient walk?

1 5 10 15 20 30 45 60 90 MINUTES

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

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

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 need to rest before returning to work? ______________

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

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?______________

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

For 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.

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/ squat	☐	☐	☐	☐
Climb ladders	☐	☐	☐	☐
Climb stairs	☐	☐	☐	☐

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

If yes, 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 <u>Twist Objects</u>	**FINGERS: Fine <u>Manipulations</u>**	**ARMS: Reaching <u>In Front of Body</u>**	**ARMS: Reaching <u>Overhead</u>**
Right:	**%**	**%**	**%**	**%**
Left:	**%**	**%**	**%**	**%**

m. 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

n. 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

o. 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 <u>absent from work</u> as a result of the impairments or treatment:

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

2. Are your patient's impairments (physical impairments plus any emotional impairments) ***reasonably consistent*** with the symptoms and functional limitations described in this evaluation? ☐ Yes ☐ No

If no, please explain:

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

4. Has there been any medical improvement in your patient's condition since treatment began? ☐ Yes ☐ No

   a. If so, please describe the medical improvement and when it occurred:

   b. If so, does this medical improvement enable your patient to work on a sustained full-time basis?

5. If there has been no medical improvement in your patient's condition, has his condition become more severe and debilitating? ☐ Yes ☐ No

____________________ ____

Date Physician Signature

Physician Name: ________________________________

Address: ________________________________

____

Telephone: ________________________________

Best time to contact: ________________________________