***STROKE MEDICAL SOURCE STATEMENT***

From:

Re: {{name}}

 (Social Security No.)

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. Did your patient have a stroke? Yes No

If yes, type of stroke:

3. Other diagnoses:

4. Prognosis:

5. Identify all of your patient's symptoms:

|  |  |  |  |
| --- | --- | --- | --- |
|   | Balance problems |   | Vertigo/dizziness |
|   | Poor coordination |   | Headaches |
|   | Loss of manual dexterity |   | Difficulty remembering |
|   | Weakness |   | Confusion |
|   | Slight paralysis |   | Depression |
|   | Unstable walking |   | Emotional lability |
|   | Falling spells |   | Personality change |
|   | Numbness or tingling  |   | Difficulty solving problems |
|   | Other sensory disturbance |   | Problems with judgment |
|   | Pain |   | Double or blurred vision |
|   | Fatigue |   | Partial or complete blindness |
|   | Bladder problems |   | Shaking tremor |
|   | Nausea |   | Speech/communication difficulties |
|  | Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

6. Clinical findings:

7. Does your patient have significant and persistent disorganization of motor function in two extremities resulting in sustained disturbance of gross and dexterous movement or gait and station? Yes No

If yes, please describe the degree of interference with locomotion and/or interference

with the use of fingers, hands and arms:

8. Do emotional factors contribute to the severity of your patient's symptoms and functional

limitations? Yes No

9. Have your patient's impairments lasted or can they be expected to last at least twelve

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 1 2 More than 2

 Minutes Hours

1. 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 1 2 More than 2

 Minutes 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. 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? %

h. 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.***

i. 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. |  |  |  |  |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|   | **Never** | **Rarely** | **Occasionally** | **Frequently** |
| Twist |  |  |  |  |
| Stoop (bend) |  |  |  |  |
| Crouch/ squat |  |  |  |  |
| Climb ladders |  |  |  |  |
| Climb stairs |  |  |  |  |

k. 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****Twist Objects** | **FINGERS:****Fine****Manipulations** | **ARMS:****Reaching****In Front of Body** | **ARMS:****Reaching****Overhead** |
|  |  |  |  |  |
| **Right:** |  **%** |  **%** |  **%** |  **%** |
|  |  |  |  |  |
| **Left:** |  **%** |  **%** |  **%** |  **%** |

l. 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 |  |  |  |  |
| Fumes, odors, gases |  |  |  |  |
| Soldering fluxes |  |  |  |  |
| Dust |  |  |  |  |
| Hazards (heights, etc.) |  |  |  |  |

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. 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 |

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, 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 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

11. 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:

12. 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:

13. What is the EARLIEST date the above limitations began? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Date Signature*

 *Printed/Typed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*7-53 Address:*

*8/09*

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