ARTHRITIS MEDICAL SOURCE STATEMENT

To:

Re: {{name}}

SS:

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

1. Frequency and length of contact:

2. Diagnoses:

3. Prognosis:

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

5. If your patient has pain, characterize the nature, location, frequency, precipitating factors,

and severity of your patient's pain:

6. Identify any positive objective signs:

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

Other clinical findings:

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

8. Identify any psychological conditions affecting your patient’s physical condition:

|  |  |
| --- | --- |
| Depression | Anxiety |
| Somatoform disorder | Personality disorder |
| Psychological factors affecting  physical condition |  |

Other:

1. Identify the side effects of any medication that may have implications for working, e.g., dizziness, drowsiness, stomach upset, etc.:

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

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 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. 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

have to rest before returning to work?

3) on such a break, will your patient need to 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.

1. 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. |  |  |  |  |

1. 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 withreaching, 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:** | **%** | **%** | **%** | **%** |

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 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

12. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. 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 affect 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 questionnaire applies?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE ABOVE LIMITATIONS BEGAN

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Completed Supervising Doctor Signature

PRINTED NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider who completed form, if different

**ATTACH BUSINESS CARD HERE**

**(or letterhead, if faxing)**