

Medical Source Statement

Patient Name: _____ Patient DOB: _____

1. Length of Treatment: _____

2. Diagnoses: _____

3. Prognosis: _____

4. List your patient's symptoms, including pain, dizziness, fatigue, etc:

5. How often would pain or other symptoms be severe enough to interfere with the attention and concentration needed to perform even simple work tasks?

Never Rarely Occasionally Frequently Constantly

6. Will your patient sometimes need to take unscheduled breaks during an 8 hour work day? Yes No

How often do you think this will happen? _____

How long will your patient need to rest? _____

7. How long would you expect your patient be able to sit, stand, and walk in an 8 hour workday:

| <u>Sit</u> | <u>Stand/Walk</u> | |
|------------|-------------------|-------------------|
| _____ | _____ | Less than 2 hours |
| _____ | _____ | 2 hours |
| _____ | _____ | 4 hours |
| _____ | _____ | 6+ hours |

8. How many lbs. do you expect your patient will be able to lift/carry frequently? _____

9. Please estimate, on average, how many days per month you would expect your patient to likely be absent from work as a result of the impairments or treatment:

Never About 1 About 2 About 3 About 4 More than 4

10. Have your patients impairments lasted, or can they be expected to last, at least 12 months? Yes No

Signature

Printed Name _____

Address _____

Date