Medical Source Statement Form

To determine this individual's ability to do work-related activities on a day-to-day basis in a regular 40-hour a week work setting, please indicate what the patient can still do despite his/her impairment(s). Do not indicate what the patient states he/she can do, but what **YOU** feel he/she can do, based on substantiated objective findings. **We need this Medical Source Statement form in addition to your narrative report and/or copies of the patient's medical records.**

1. A. Are LIFTING/CARRYING affected by the impairment(s)? _____ YES _____ NO
(If no, skip to #2)

B. What is the patient's maximum capacity to LIFT and/or CARRY?

Occasionally (Up to 1/3 (cumulative not continuous) of an 8-hour workday.)

_____ less than 10 pounds
_____ 10 pounds
_____ 20 pounds
_____ 50 pounds
_____ 100 pounds

On which of your findings have you based this conclusion?
_____
_____
_____
_____

Frequently (1/3 to 2/3 (cumulative not continuous) of an 8-hour workday.)

_____ less than 10 pounds
_____ 10 pounds
_____ 20 pounds
_____ 50 pounds
_____ 100 pounds

On which of your findings have you based this conclusion?
_____
_____
_____
_____

2. A. What is the patient's ability to STAND and/or WALK, with normal breaks?

_____ less than 2 hours in an 8-hour workday
_____ at least 2 hours in an 8-hour workday
_____ about 6 hours in an 8-hour workday

On which of your findings have you based this conclusion? _____
_____

B. Does the patient use an assistive device? _____ YES _____ NO
If yes, what kind and under what circumstances? _____
_____
Who prescribed it? _____
Is it medically necessary? _____ YES _____ NO
On which of your findings have you based this conclusion? _____
_____

3. What is the patient's ability to SIT, with normal breaks?

_____ less than 2 hours in an 8-hour workday
_____ about 6 hours in an 8-hour workday

How many hours? _____

On which of your findings have you based this conclusion? _____
_____
_____

4. If the patient needs to ALTERNATE STANDING AND SITTING, do breaks and lunch periods provide sufficient relief? _____ YES _____ NO _____ N/A

If not, how often and for how long? _____

On which of your findings have you based this conclusion? _____

_____

5. Which of the following can the patient do?

	Frequently (1/2 to 2/3 of day)	**Occasionally** (up to 1/3 of day)	**Never**		**Unlimited**	**Limited** R/L
Climbing	_____	_____	_____	Reaching	_____	____/____
Balancing	_____	_____	_____	Handling	_____	____/____
Stooping	_____	_____	_____	Fingering	_____	____/____
Kneeling	_____	_____	_____	Feeling	_____	____/____
Crouching	_____	_____	_____	Seeing	_____	____/____
Crawling	_____	_____	_____	Hearing	_____	____/____
				Speaking	_____	____/____

If there are any restrictions, please give the degree of limitation and supportive evidence.

_____

_____

_____

_____

6. Are there any environmental restrictions caused by the patient's impairment(s)?

Heights	_____ YES	_____ NO
Moving Machinery	_____ YES	_____ NO
Temperature Extremes	_____ YES	_____ NO
Chemicals	_____ YES	_____ NO
Dust	_____ YES	_____ NO
Other	_____ YES	_____ NO

On which of your findings have you based this conclusion? _____

_____

_____

_____

7. **What is the prognosis and recommendation for treatment?** _____

_____

_____

_____

_____

Signature/Title/Specialty Telephone Date

_____

Please Print or Type Name