PERIPHERAL NEUROPATHY MEDICAL SOURCE STATEMENT

From: ______________________________

Re: ______________________________ (Name of Patient)

______________________________ (Social Security No.)

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

1. Frequency and length of contact: ______________________________

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

3. List any other diagnosed impairments: ______________________________

____

4. Prognosis: ______________________________

5. Identify your patient's symptoms and signs:

☐ Pain	☐ Weakness
☐ Paresthesias	☐ Sensory loss
☐ Abnormal gait	☐ Decreased deep tendon reflexes
☐ Deficiencies in joint proprioception	☐ Chronic fatigue
☐ Urinary incontinence	☐ Fecal incontinence
☐ Diarrhea	☐ Cramping, burning calves & feet
☐ Postural hypotension	☐ Muscle atrophy

Other symptoms, signs and clinical findings: ______________________________

____

____

6. If your patient has pain/ paresthesias, characterize the severity of the pain/ paresthesias:

☐ Mild ☐ Moderate ☐ Severe

Describe the location and frequency of your patient's pain/ paresthesias:

____

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

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8. Identify any associated psychological problems/ limitations:

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

9. Identify **side effects** of any medications that may have implications for working:

☐ Drowsiness/ sedation ☐ Other: ______________________________

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 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 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, 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

If yes, how ***often*** must your patient walk? 1 5 10 15 20 30 45 60 90 Minutes

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) what symptoms cause a need for breaks?

- ☐ Muscle weakness
- ☐ Pain/ paresthesias, numbness
- ☐ Chronic fatigue
- ☐ Adverse effects of medication
- ☐ Other: ______________________________

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? ________________

3) what symptoms cause a need to elevate the leg(s)? ______________

i. While engaging in occasional standing/walking, must your patient use a cane or other hand-held 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	☐	☐	☐	☐

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

If yes, what symptoms cause limitations of use of the upper extremities?

- ☐ Pain/ paresthesias
- ☐ Motor loss
- ☐ Sensory loss/ numbness
- ☐ Muscle weakness
- ☐ Swelling
- ☐ Side effects of medication
- ☐ Limitation of motion
- ☐ Other: ______________________________

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

Please explain the reasons for your conclusion: ______________________

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

11. Are your patient's impairments (physical impairments plus any emotional impairments) as demonstrated by signs, clinical findings and laboratory or test results ***reasonably consistent*** with the symptoms and functional limitations described above in this evaluation?
☐ Yes ☐ No

If no, please explain: ______________________

12. Please describe any other limitations (such as 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:

____

____

____

____

______________________ ______________________
Date *Signature*

Printed/Typed Name: ______________________

Address: ______________________

____

____

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§239.7

CHRONIC PANCREATITIS
MEDICAL ASSESSMENT FORM

TO: Dr.________________________

RE: ___________________________

SSN: ___________________________

Please answer all the following questions concerning your patient's pancreatitis and other health problems. *Attach all relevant treatment notes, laboratory and test results which have not been provided previously to the Social Security Administration.*

1. Date began treatment:________________ Frequency of tx: ____________________

2. Does your patient exhibit chronic pancreatitis? ☐ Yes ☐ No

   Other diagnoses: ____

3. Identify any **symptoms or signs** that your patient exhibits due to his/her impairments:

   ☐ recurrent nausea/vomiting
   ☐ sleep disturbance
   ☐ recurrent fevers
   ☐ recurrent/persistent diarrhea
   ☐ recurrent dizzy spells
   ☐ urinary frequency/incontinence
   ☐ weakness
   ☐ poor appetite with weight loss
   ☐ emesis
   ☐ lower extremity edema
   ☐ chronic fatigue
   ☐ radiation of abdominal pain to the back
   ☐ bowel incontinence
   ☐ persistent/recurrent abdominal pain, cramping and tenderness
   ☐ other: ____

   A. If your patient exhibits **bladder incontinence**, how often does this usually occur?
   _________ per week _________ per month ________________________________

   B. If your patient exhibits **bowel incontinence**, how often does this usually occur?
   _________ per week _________ per month ________________________________

4. Identify positive clinical findings and test results (e.g., ultrasound, ERCP):______________
   ____

5. Does your patient **currently** abuse alcohol or street drugs? ☐ Yes ☐ No

6. Does your patient experience symptoms which interfere with the **attention and concentration** needed to perform even simple work tasks, so that if your patient was working s/he would likely be **"off task" at least 15%** of the time? ☐ Yes ☐ No

7. If your patient was placed in a competitive job, identify those aspects of workplace stress that your patient would be unable to perform or be exposed to:
   - ☐ routine, repetitive tasks at consistent pace
   - ☐ detailed or complicated tasks
   - ☐ frequent interaction with coworkers/supervisors/public
   - ☐ fast paced tasks (e.g., production line)

8. Identify any **side effects** of any medications which may have implications for working:
   ☐ drowsiness/sedation ☐ other: ___________________________________

9. As a result of your patient's impairment(s), estimate your patient's functional limitations assuming your patient was placed in a *competitive work situation* on an ongoing basis:

   A. How many city blocks can the patient **walk** without rest or severe pain? _________

   B. Please circle the hours and/or minutes that your patient can *continuously* **sit and stand** *at one time:*

   1. **Sit:** 0 5 10 15 20 30 45 Minutes 1 2, More than 2 Hours

   What must your patient usually do after sitting this long?
   ☐ walk ☐ stand ☐ lie down ☐ other: _____________________

   2. **Stand:** 0 5 10 20 30 45 Minutes 1 2, More than 2 Hours

   What must your patient usually do after standing this long?
   ☐ walk ☐ sit ☐ lie down ☐ other: _____________________________

   C. Please indicate how long your patient can sit and stand/walk *total in an eight hour work day* (with normal breaks)?

Sit	Stand/Walk	
☐	☐	less than 2 hours
☐	☐	about 2 hours
☐	☐	about 4 hours
☐	☐	at least 6 hours

   D. Does your patient need a job which permits **ready access** to a restroom?☐Yes☐ No

   E. If your patient sometimes needs to take unscheduled **restroom breaks** during an eight-hour workday, **how many times** during an average workday do you expect this to happen? 0 1 2 3 4 5 6 7 8 9 10, more than 10

   F. In addition to the above-discussed restroom breaks, if your patient also sometimes needs to take **additional unscheduled breaks** to lie down, change soiled clothing, rest, etc., during an eight-hour workday, **how many times** during an average workday do you expect this to happen?

   0 1 2 3 4 5 6 7 8 9 10, more than 10

G. Due to your patient's symptoms, should your patient **elevate leg(s)** at least two hours during a typical eight-hour daytime period? ☐ Yes ☐ No

If yes, how high should leg(s) typically be elevated:

☐	at or above heart level	☐	waist level
☐	between heart and waist level	☐	below waist level

H. How many pounds can the patient **lift and carry** in a competitive work situation?

	Never	Rarely	Occasionally	Frequently
Less than 10 lbs.		☐	☐	☐
10 lbs.	☐	☐	☐	☐
20 lbs.	☐	☐	☐	☐
50 lbs.	☐	☐	☐	☐

I. Imagine that your patient was hired to perform competitive full-time work. Please estimate, on average, how often your patient would experience "bad days" so that your patient would be **absent** from work as a result of the impairment(s) or treatment:

☐ never/*less than once* a month
☐ about *once or twice* a month
☐ about *three* days a month
☐ about *four* days a month
☐ *more than four* days a month

Date: ____________________________ Signed: ______________________________________

Print Name: __________________________________