§238.1 Form: Diabetes Mellitus Medical Source Statement

DIABETES MELLITUS MEDICAL SOURCE STATEMENT

From: ______________________

Re: ______________________(Name of Patient)

______________________(Social Security No.)

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

1. Frequency and length of contact:______________________

2. Diagnoses: ______________________

3. Prognosis: ______________________

4. Identify all of your patient's ***symptoms***:

☐ Fatigue
☐ Difficulty walking
☐ Episodic vision blurriness
☐ Bladder infections
☐ Bed wetting
☐ Infections/fevers
☐ Excessive thirst
☐ Rapid heart beat/chest pain
☐ Swelling
☐ Chronic skin infections
☐ Sensitivity to light, heat or cold
☐ General malaise
☐ Muscle weakness
☐ Retinopathy
☐ Kidney problems
☐ Hot flashes
☐ Psychological problem
☐ Abdominal pain
☐ Vascular disease/ leg cramping
☐ Insulin shock/coma
☐ Nausea/vomiting
☐ Extremity pain and numbness
☐ Loss of manual dexterity
☐ Diarrhea
☐ Frequency of urination
☐ Sweating
☐ Difficulty thinking/ concentrating
☐ Dizziness/loss of balance
☐ Headaches
☐ Hyper/hypoglycemic attacks
☐ Other: ______________________

5. Clinical findings: ______________________

6. Describe the treatment and response including any side effects of medication that may have implications for working, *e.g.*, drowsiness, dizziness, nausea, etc:

____

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

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

9. Identify any psychological conditions affecting your patient's physical condition:

☐ Depression
☐ Anxiety
☐ Somatoform disorder
☐ Personality disorder
☐ 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

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? ____________

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.

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	☐	☐	☐	☐
Climb ladders	☐	☐	☐	☐
Climb stairs	☐	☐	☐	☐

l. If your patient has significant limitations with reaching, handling or fingering, 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. 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	☐	☐	☐	☐
Cigarette smoke	☐	☐	☐	☐
Perfumes	☐	☐	☐	☐
Soldering fluxes	☐	☐	☐	☐
Solvents/cleaners	☐	☐	☐	☐
Fumes, odors, gases	☐	☐	☐	☐
Dust	☐	☐	☐	☐
Chemicals	☐	☐	☐	☐
List other irritants: ________________	☐	☐	☐	☐

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. 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: ______________________

p. 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 one day per month
☐ About two days per month
☐ About three days per month
☐ About four 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:

____

____

____

______________________ ______________________
Date *Signature*

Printed/Typed Name: ______________________

Address: ______________________

____

7-46
8/09
§238.1

§238.2 Form: Obesity Medical Source Statement

OBESITY MEDICAL SOURCE STATEMENT

From: ______________________________

Re: ______________________________(Name of Patient)

______________________________(Social Security No.)

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. Does your patient meet the criteria for the diagnosis of obesity as defined by the National Institutes of Health (a Body Mass Index* of 30.0 kg/m^2)? ☐ Yes ☐ No
   *BMI is the ratio of patient weight in kilograms to the square of the patient's height in meters.

3. a. What is your patient's current weight? ________ b. Current height? ______________

4. Other Diagnoses: ____

5. Prognosis: ____

6. List your patient's ***symptoms***, including pain, shortness of breath, fatigue, etc:

   ____

7. If your patient has pain, shortness of breath, fatigue, etc., characterize the nature, location, frequency, precipitating factors, and severity of your patient's symptoms:

   ____

   ____

8. Identify the clinical findings and objective signs:

   ____

   ____

9. Describe the treatment and response including any side effects of medication that may have implications for working, e.g., drowsiness, dizziness, nausea, etc:

   ____

   ____

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

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

12. Identify any psychological conditions affecting your patient's physical condition:

☐ Depression	☐ Anxiety
☐ Somatoform disorder	☐ Personality disorder
☐ Psychological factors affecting physical condition	☐ Other: ____________________

13. 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

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? ____________

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.

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	☐	☐	☐	☐
Climb ladders	☐	☐	☐	☐
Climb stairs	☐	☐	☐	☐

l. 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 <u>Twist Objects</u>	**FINGERS: Fine <u>Manipulations</u>**	**ARMS: Reaching <u>In Front of Body</u>**	**ARMS: Reaching <u>Overhead</u>**
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

14. 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

15. 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:

____

____

____

______________________ ______________________________
Date *Signature*

Printed/Typed Name: ______________________________

Address: ______________________________

____

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7-39
8/09
§238.2