Disability Help Group

INSTRUCTIONS

To complete this form, read from top to bottom, and then left to right. The questions are numbered and sequential.

Please provide your medical opinion regarding how the individual's physical abilities are affected by any physical conditions you have diagnosed or of which you are aware. If there is no impairment, please indicate accordingly. Your medical opinion **SHOULD NOT** be based upon the individual's subjective complaints if those complaints are not verified by your treatment, observation, and experience treating the individual. The form should also view the medical conditions in light of how well the individual functions while on medications not in the absence of medical treatment. i.e, if the individual's symptoms or dysfunction are resolved by medications this should be indicated and the individual will not meet criteria for disability.

This form will be submitted as evidence of this individual's abilities regarding physical work activities in a regular work setting in the U.S. economy. A regular work setting is one where the individual would be required to work 8 hours a day, 5 days a week, with a work break in the morning for 15 minutes, a work break in the afternoon for 15 minutes, and 30 minutes for lunch. **DO NOT CONSIDER** factors such as the individual's age, education, or past work experience. These factors will be considered at other points in the disability determination process.

We have provided a self- addressed stamped envelope if you do not wish to provide the form to the client directly. Please make a copy of the form for your records in the event something gets lost in the mail. If you have any questions about the form, please contact us directly at 800-800-3332.

Medical Source Statement: Remaining Ability to Do Physical Activities

Patient Name:
Patient Last 4 SSN:

Please list for what physical health conditions you are treating the patient:

_____

_____

_____

1. **Does the patient have any problems sitting or maintaining a seated position?**

   ☐ Yes ☐ No ☐ Unknown

2. **How long could they reasonably be expected to sit in a regular office chair in total throughout an 8 hour workday?**

   ☐ 2 hours out of an 8 hour workday.
   ☐ 2-3 hours out of an 8 hour workday.
   ☐ 3-4 hours out of an 8 hour workday.
   ☐ 4-5 hours out of an 8 hour workday.
   ☐ 5-6 hours out of an 8 hour workday.
   ☐ 6-8 hours out of an 8 hour workday.
   ☐ Unknown to me or unable to evaluate.

3. **If the patient has any issues maintaining a seated position, would any of the following be medically necessary for them to remain seated and productive for more than 1 hour at a time?**

   ☐ Elevating their leg(s) above waist level.
   ☐ Sitting in a recliner or a reclined position.
   ☐ A specialized/custom orthotic chair.
   ☐ Ability to alternate between sitting and standing positions at will.
   ☐ None of these.
   ☐ Other _____

   Please feel free to use the space below to explain:

   _____

   _____

   _____

4. **Does the patient have any difficulties standing and walking?**

   ☐ Yes ☐ No ☐ Unknown

5. **If yes, are any of the following assistive devices medically necessary for them to move about or travel safely?**

   ☐ Cane ☐ Crutches
   ☐ Walker ☐ Wheelchair
   ☐ No ☐ Other _____

6. **If an assistive device is necessary, please explain the medical basis for your position:**

   ☐ Risk of falling due to weakness, balance or loss of equilibrium.
   ☐ Required to rise from seated to standing position.
   ☐ Alleviates pain or pressure while standing/walking.
   ☐ Required to provide break while standing or walking.

   ☐ Other _____

7. **If you found issues with standing and walking, how long could the patient stand and walk *at one time*, without the use of an assistive device?**

   ☐ 15 minutes or less. ☐ 16-30 minutes.
   ☐ 31-45 minutes. ☐ 45 minutes to 1 hour
   ☐ 1-2 hours. ☐ 2 hours continuously

8. **If the patient has any issues standing and walking, how long could they reasonably be expected to stand/walk in total throughout an 8 hour workday?**

   ☐ 2 hours out of an 8 hour workday.
   ☐ 2-3 hours out of an 8 hour workday.
   ☐ 3-4 hours out of an 8 hour workday.
   ☐ 4-5 hours out of an 8 hour workday.
   ☐ 5-6 hours out of an 8 hour workday.
   ☐ 6-7 hours out of an 8 hour workday.
   ☐ Unknown to me or unable to evaluate.

9. Do any of the following apply regarding the patient abilities to stand/walk?

- ☐ Limitations with standing/walking interferes seriously with their ability to independently initiate, sustain, and complete their activities.
- ☐ Not capable of sustaining a reasonable walking pace over a sufficient distance to be able to carry out activities of daily living.
- ☐ Does not have the ability to travel without companion assistance outside of home.
- ☐ Inability to walk a block at a reasonable pace on rough or uneven surfaces.
- ☐ Inability to use standard public transportation.
- ☐ Inability to carry out routine ambulatory activities such as shopping or banking.
- ☐ Inability to climb a few steps at a reasonable pace with the use of a single hand rail.

Please feel free to use the space below to explain:

_____

_____

_____

_____

10. In your medical opinion, are there limits on the amount of weight the patient should lift and carry?

☐ Yes ☐ No ☐ Unknown

11. If yes, what amount of weight could the patient safely be able to lift/carry for 1/3 of an 8 hour workday (2.64 hours)?

☐ 1-5 pounds	☐ 6-10 pounds
☐ 11-15 pounds	☐ 16-20 pounds
☐ 21-25 pounds	☐ 25-50 pounds
☐ 51-100 pounds	☐ > 100 pounds

12. If yes, what amount of weight could the patient safely be able to lift/carry for 2/3 of an 8 hour workday (5.28 hours).

☐ 1-5 pounds	☐ 6-10 pounds
☐ 11-15 pounds	☐ 16-20 pounds
☐ 21-25 pounds	☐ 25-50 pounds
☐ 51-10 pounds	☐ >100 pounds

13. Does the patient have any issues using their arms for activities shown below?

☐ Pushing/Pulling (overhead)	☐ Reaching
☐ Reaching (in front)	☐ Reaching (below)

If yes, which arm or both:

☐ Right ☐ Left ☐ Both

14. If yes, how much of an 8 hour workday would the patient be able to productively use their arms for reaching, pushing or pulling?

- ☐ 0-1 ½ hours out of an 8 hour workday.
- ☐ 1 ½ hours – 3 hours out of an 8 hour workday.
- ☐ 3-4 hours out of an 8 hour workday.
- ☐ 4-6 hours out of an 8 hour workday.
- ☐ 6+ hours out of an 8 hour workday.
- ☐ Unknown to me or unable to evaluate.

15. Does the patient have any limitations in the use of their hands?

☐ Yes ☐ No ☐ Unknown

If yes, which hand does it impact?

☐ Right ☐ Left ☐ Both

16. If yes, which of the following activities/ abilities would be impacted/limited?

- ☐ Typing/Writing
- ☐ Gripping/Grasping
- ☐ Manual Assembly
- ☐ Manual Insertion
- ☐ Fingering/Threading
- ☐ Turning/Twisting
- ☐ Activities requiring fine manipulations
- ☐ Activities requiring manual dexterity
- ☐ Activities requiring feel or touch
- ☐ Activities requiring fine or manual precision
- ☐ Other _____

17. If yes, how much of an 8 hour workday would the patient be able to productively use their hands?

- ☐ 1 hour out of an 8 hour workday.
- ☐ 1-2 hours out of an 8 hour workday.
- ☐ 2-3 hours out of an 8 hour workday.
- ☐ 3-4 hours out of an 8 hour workday.
- ☐ 4-5 hours out of an 8 hour workday.
- ☐ 5-6 hours out of an 8 hour workday.
- ☐ 6+ hours out of an 8 hour workday.

Please feel free to us the space below to explain the extent of the limits and what causes them:

_____

_____

18. Do any of the following impact the patient's ability to function physically?

- ☐ Side effects from medication
- ☐ Pain level
- ☐ Fatigue, exhaustion, or weakness
- ☐ Dizziness, lightheadedness, confusion
- ☐ Shortness of breath
- ☐ Other _____

If you checked yes, please indicate how serious are the symptoms discussed above?

- ☐ **Mild:** generally perform well with only short or infrequent difficulty or interference.
- ☐ **Moderate:** difficulties or interference in concentration, persistence, or pace up to 1/3 of an 8 hour time span such that they would not be productive during that time period.
- ☐ **Marked:** difficulties or interference in concentration, persistence, and pace up to 2/3 of an 8 hour time span such that they would not be productive during that time period.

19. Is there any other information you feel is relevant/important to consideration of the issue of whether or not the patient is capable of engaging in competitive employment on a regular and consistent basis?

_____

_____

_____

_____

_____

20. May a representative from the Social Security Administration contact your office regarding the opinions enclosed herein?

☐ Yes ☐ No

Onset date Questionnaire (FORM MUST BE SIGNED)

I have treated the patient since _____.

It is my opinion that the patient has had the limitations and restrictions outlined in the

Residual Functional Capacity Form since _____.

My opinion is based on:

_____Direct Observation/Treatment	_____Historic Medical Records
_____Clinical Testing	_____Labs, Imaging, or Other Diagnostic Tests
_____Patient Report	_____Physical Examination
_____Functional Testing	_____Other: _____
_____My Own Experience & Background	_____Other: _____

_____ _____

Date Name and Title of Individual Completing the Report

***If form was not completed by a doctor, it must be reviewed by doctor to be given appropriate weight. By signing below, the physician indicates they reviewed this assessment and agrees with the medical opinions contained herein.

_____ _____

Date Doctor's Printed Name and Signature