MEDICAL SOURCE STATEMENT
Physical Disorders

INSTRUCTIONS: Please complete the following statement based on your clinical evaluation and test findings. **You are not required to perform a functional capacity evaluation to render your opinion on this form.**

Patient Name: _____ Patient Since: _____ Frequency: _____

1. Diagnoses: _____

2. Prognosis: _____

2. Symptoms (i.e., pain, dizziness, fatigue): _____
_____

3. Supportive diagnostic imaging (i.e., x-rays, MRIs): _____
_____

4. Objective signs and findings: _____
_____

5. Side effects of prescription and non-prescription medications that have implications for working (i.e., lethargy, drowsiness, dizziness, fatigue, nausea, upset stomach, etc.): _____
_____

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

7. Is your patient a malingerer? ☐ Yes ☐ No

8. Is a cane/assistive device medically necessary? ☐ Yes ☐ No
(If yes, what type? _____)
(If yes, for: ☐ Ambulation ☐ Balance ☐ Both)

I. EXERTIONAL LIMITATIONS

9. Please indicate how long (hours) your patient can sit, stand/walk, and lie down **total** in an 8-hour workday:

Stand/walk:	0-2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐
Sit:	0-2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐
Lie down:	0-2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐

10. Please indicate how long (minutes) your patient can sit and stand/walk **at one time** in an 8-hour workday:

Stand/walk: _____
Sit: _____

For this and all other questions on this form, "rarely" means 1% to 5% of an 8-hour workday, "occasionally" means 6% to 33% of an 8-hour workday, and "frequently" means 34% to 66% of an 8-hour workday.

11. How many pounds can your patient lift and carry in a competitive work situation? (check all that apply)

	Never	Rarely	Occasionally	Frequently	Additional Comments (Optional)
>10 lbs.					
10 lbs.					
20 lbs.					
50 lbs.					

12. How often can your patient push and/or pull (including operating hand or foot controls)?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently

II. POSTURAL LIMITATIONS

Check the blocks representing your patient's ability to perform the following:

	Never	Rarely	Occasionally	Frequently
1. Climbing ramps/stairs				
2. Balancing				
3. Stooping				
4. Kneeling				
5. Crouching				
6. Crawling				

III. MANIPULATIVE LIMITATIONS

13. Please indicate how often your patient can use his or her fingers/hands/arms effectively for the following activities:

	Never	Rarely	Occasionally	Frequently
1. Grasp, turn, or twist objects (right)				
2. Grasp, turn, or twist objects (left)				
3. Fine manipulation (right)				
4. Fine manipulation (left)				
5. Reach (including overhead) (right)				
6. Reach (including overhead) (left)				

IV. VISUAL LIMITATIONS

14. Please indicate your patient's visual limitations, if any:

	Limited	Unlimited
1. Near acuity		
2. Far acuity		
3. Depth perception		
4. Accommodation		
5. Color vision		
6. Field of vision		

V. NONEXERTIONAL LIMITATIONS

15. How often during a typical workday are your patient's experiences of pain severe enough to interfere with attention and concentration needed to perform simple work tasks? ☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently

16. Please estimate, on the average, how many days per month your patient is likely to be absent from work as a result of his/her physical and/or mental impairments and/or his/her need for ongoing and periodic medical treatment and care for them. ☐ 1 day or less ☐ 2 days ☐ 3 days ☐ 4 days ☐ 5 days or more

17. State any other work-related activities, which are affected by the impairment, and indicate how the activities are affected. What are the medical/clinical findings that support this assessment?

VI. CAPABILITY TO MANAGE BENEFITS

18. Can the individual manage benefits in his or her own best interest? ☐ Yes ☐ No

SIGNATURE/TITLE/MEDICAL SPECIALITY **PRINTED NAME** **DATE**