AUTO IMMUNE DISORDER
MEDICAL ASSESSMENT FORM

TO: Dr._____

Re: _____

SSN: _____

Please answer all the following questions concerning your patient's auto immune 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 have an auto immune disorder? ☐ Yes ☐ No

   If yes, if possible, identify the type of auto immune disorder: _____
   _____

   Other diagnoses: _____

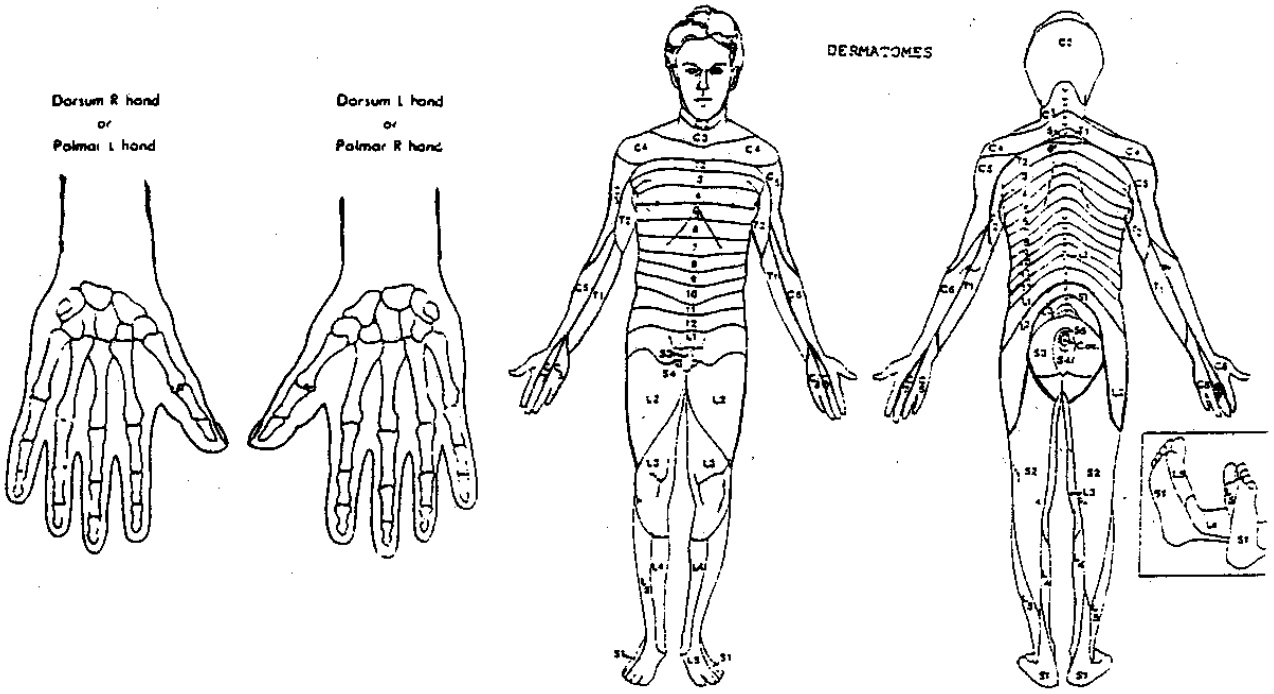
3. Identify any test results, symptoms or signs that your patient exhibits due to his/her impairment (or adverse effects of treatments):

☐ bladder infections	☐ yeast infections	☐ oral ulcers
☐ urinary urgency or incontinence	☐ headaches	☐ low grade fever
☐ chronic sinusitis	☐ recurrent bronchitis	☐ weight loss
☐ Raynaud's phenomenon	☐ anxiety	☐ depression
☐ peritonitis	☐ disturbed sleep	☐ candida
☐ aspergillus	☐ herpes complex	☐ vertigo
☐ recurrent sore throat	☐ septic arthritis	☐ neuropathy
☐ endocarditis	☐ chronic diarrhea	☐ chronic fatigue
☐ night sweats	☐ renal involvement	☐ hemolytic anemia
☐ lypophopenia	☐ nausea/vomiting	☐ severe malaise
☐ abdominal cramping/pain	☐ visual disturbances	☐ lymph node enlargement

   ☐ other: _____
   _____

4. Identify and positive clinical findings and test results (e.g., granulocytopenia, T and B cell deficiency, hypogammaglobulinemia, positive ANA etc.):
   _____
   _____

5. Identify the location and frequency of pain/paresthesia by shading the relevant body portions and labeling as constant (C), frequent (F), intermittent (I):



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 bathroom?
☐ Yes ☐ No

E. If your patient's symptom(s) would likely cause the need to take unscheduled **restroom breaks** during an average 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 you feel that your patient will also sometimes need 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. While engaging in even occasional standing/walking must your patient use a cane or other assistive device for balance? ☐ Yes ☐ No

I. 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.	☐	☐	☐	☐

J. How often can your patient perform the following waist level activities?

	Never	Rarely	Occasionally	Frequently
Twist	☐	☐	☐	☐
Stoop (bend)	☐	☐	☐	☐

K. If your patient has significant limitations with reaching, handling or fingering, please estimate the percentage of time during an eight-hour workday that your patient can use hands/fingers/arms for the following activities:

	HANDS: Grasp, Turn Twist Objects	**FINGERS: Fine Manipulations**	**ARMS: Reaching (inc. Overhead)**
Right	_____%	_____%	_____%
Left	_____%	_____%	_____%

L. State the degree to which your patient should avoid the following:

ENVIRONMENTAL RESTRICTIONS:	NO RESTRICTION	AVOID CONCENTRATED OR EVEN MODERATE EXPOSURE	AVOID ALL EXPOSURE
Cold			
Heat			
High humidity			
Sunlight			
Ultraviolet light			
Other:			

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: _____

Address: _____

Name _____ **SSN** _____

Please assess your patient's mental abilities within the context of the individual's capacity to sustain activities over a normal workday and workweek, on a ongoing basis in a competitive work environment.

THE HIGHER THE NUMBER THE GREATER THE DEGREE OF IMPAIRMENT.

1.	**able to perform** designated task or function with no observable limits.
2.	able to perform designated function, but has or will have noticeable difficulty (e.g., distracted from job activity) **about 10% or less** of a typical work day (up to about one hour/day).
3.	able to perform designated function, but has or will have noticeable difficulty (distracted from job activity) **about 15%** of a typical work day (more than one hour/day).
4.	able to perform designated function, but has or will have noticeable difficulty (distracted from job activity) **about 20%** of the work day (more than 1½ hours/day or about one day/week).
5.	**not able to perform** designated function on regular, reliable, and sustained schedule basis.

	1	2	3	4	5
Understand, remember and carry out simple, one- or two-step instructions	☐	☐	☐	☐	☐
Understand, remember and carry out detailed instructions	☐	☐	☐	☐	☐
Maintain attention and concentration for at least two straight hours, a few times a day	☐	☐	☐	☐	☐
Perform activities within a schedule and be punctual within customary tolerances	☐	☐	☐	☐	☐
Sustain ordinary routine without special supervision	☐	☐	☐	☐	☐
Complete a normal workday/week without interruptions from symptoms which cause an unreasonable number (more than three/day) and length of rest periods	☐	☐	☐	☐	☐
Perform accurately and at a consistent pace	☐	☐	☐	☐	☐
Accept instructions and respond appropriately to criticism from supervisors	☐	☐	☐	☐	☐
Work in coordination with or proximity to co-workers without being distracted or distracting them or exhibiting behavioral extremes	☐	☐	☐	☐	☐
Deal with stresses of skilled/semiskilled work	☐	☐	☐	☐	☐
Interact appropriately with the general public	Yes ☐		No ☐		
Travel alone to workplace incl. use of public transportation	Yes ☐		No ☐		

Signature: _____ **Date:** _____