BLADDER PROBLEM 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 results as appropriate.*

1. Frequency and length of contact: ______________________________

2. Diagnoses: ______________________________

3. Prognosis: ______________________________

4. List your patient's symptoms, including urinary frequency, urinary incontinence, etc.:

   ____

   ____

5. Identify the clinical findings and objective signs:

   ____

   ____

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
   ☐ Psychological factors affecting physical condition ☐ Personality disorder

   Other: ______________________________

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10. Does your patient have urinary frequency? ☐ Yes ☐ No

    If yes, please estimate approximately how often your patient must urinate. ___________

11. Does your patient have urinary incontinence? ☐ Yes ☐ No

    If yes, a) please estimate approximately how often your your patient is incontinent: ___________________

    b) please estimate the volume of urine involved: ___________________

12. What makes your patient's urinary frequency/ incontinence better?

    ____

    ____

13. What makes your patient's urinary frequency/ incontinence worse?

    ____

    ____

14. 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: ________________________________

15. 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 stopping? ______

    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 a job that permits ready access to a restroom? ☐ Yes ☐ No

g. Will your patient sometimes need to take unscheduled restroom breaks during a working day? ☐ Yes ☐ No

If yes, 1) how ***often*** do you think this will happen? ______________________

2) how ***long*** will your patient be away from the work station for an average unscheduled restroom break? ______________________

3) how much advance notice does your patient have of the need for a restroom break? ______________________

h. Will your patient sometimes need to clean up and change clothes following urinary incontinence during an 8-hour working day? ☐ Yes ☐ No

If yes, how ***often*** do you think this will happen? ______________________

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.

i. 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.	☐	☐	☐	☐

j. How often can your patient perform the following activities?

	Never	**Rarely**	**Occasionally**	**Frequently**
Twist	☐	☐	☐	☐
Stoop (bend)	☐	☐	☐	☐
Crouch/ squat	☐	☐	☐	☐
Climb ladders	☐	☐	☐	☐
Climb stairs	☐	☐	☐	☐

k. 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

l. 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

16. 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: ____________________

17. Please describe any other limitations (such as limitations using hands, arms, fingers, 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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