

CARDIAC ARRHYTHMIA 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. Does your patient have arrhythmias? ☐ Yes ☐ No

If yes, are they ☐ atrial/ supraventricular arrhythmias or ☐ ventricular arrhythmias?

3. Other cardiac diagnoses (with New York Heart Association functional classification):

4. Prognosis: _____

5. If your patient has episodes of arrhythmia,

a. Identify your patient's symptoms:

- | | | |
|--|---|--|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Syncope | <input type="checkbox"/> Chronic fatigue |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Edema | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Near syncope | <input type="checkbox"/> Light headedness | |

b. How often do episodes typically occur?

- | | |
|---|--|
| <input type="checkbox"/> Seldom or never | <input type="checkbox"/> Daily |
| <input type="checkbox"/> Several times a week but less often than daily | <input type="checkbox"/> Several times a day |

c. How long do episodes typically last? _____

d. If your patient must typically rest after an episode, how long will your patient typically rest?

6. Identify clinical findings, laboratory and test results that show your patient's impairments:

- [illegible]

- 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	
<input type="checkbox"/>	<input type="checkbox"/>	less than 2 hours
<input type="checkbox"/>	<input type="checkbox"/>	about 2 hours
<input type="checkbox"/>	<input type="checkbox"/>	about 4 hours
<input type="checkbox"/>	<input type="checkbox"/>	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. 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? _____

- g. 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? _____ %

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.

- h. How many pounds can your patient lift and carry in a competitive work situation?

	Never	Rarely	Occasionally	Frequently
Less than 10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- i. 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extreme heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High humidity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wetness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cigarette smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perfumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soldering fluxes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Solvents/cleaners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fumes, odors, gases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dust	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemicals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
List other irritants: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- j. 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

- k. 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) as demonstrated by signs, clinical findings and laboratory or test results *reasonably consistent* with the symptoms and functional limitations described above in this evaluation?
☐ Yes ☐ No

If no, please explain: _____

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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