## CARDIAC ARRHYTHMIA MEDICAL SOURCE STATEMENT

	e answer the following questions ment notes, radiologist reports, la  Frequency and length of contact:  Does your patient have arrhythm	(Social Security No. concerning your patient's in boratory and test results as	mpairments. <i>Attach relevan</i>	ıt								
	e answer the following questions ment notes, radiologist reports, la  Frequency and length of contact:	concerning your patient's in boratory and test results as	mpairments. Attach relevan appropriate.	!t								
	ment notes, radiologist reports, la  Frequency and length of contact:	boratory and test results as	appropriate.	!t								
	-											
1.	Does your patient have arrhythm											
2.		ias?	☐ Yes ☐ ]	No								
	If yes, are they $\square$ atrial/suprave	ntricular arrhythmias or $\Box$	lar arrhythmias or  uentricular 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:											
	<ul><li>☐ Chest pain</li><li>☐ Weakness</li><li>☐ Shortness of breath</li><li>☐ Near syncope</li></ul>	☐ Syncope ☐ Palpitations ☐ Edema ☐ Light headedness	<ul><li>☐ Chronic fatigue</li><li>☐ Nausea</li><li>☐ Dizziness</li></ul>									
	b. How often do episodes typica	lly occur?										
	☐ Seldom or never☐ Several times a week	but less often than daily	<ul><li>□ Daily</li><li>□ Several times a day</li></ul>									
	c. How long do episodes typically last?											
	d. If your patient must typically rest?	rest after an episode, how l		lly								
6.	Identify clinical findings, laborate			ts:								

<b>.</b>	if your patient has an implanted defibrillator and experiences frequent snocks,										
	a. What is the frequency of shocks?										
	b. What are the reasons for frequent shocks?										
3.	Describe the treatment and response including any side effects of medication that may have implications for working, $e.g.$ , drowsiness, dizziness, nausea, etc:	ve									
<b>)</b> .	a. What is the role of stress in bringing on your patient's symptoms?										
	b. To what degree can your patient tolerate work stress?										
	<ul> <li>☐ Incapable of even "low stress" work</li> <li>☐ Capable of low stress work</li> <li>☐ Capable of high stress work</li> </ul>										
	Please explain the reasons for your conclusion:										
10.	Do your patient's physical symptoms and limitations cause emotional difficulties such as depression or chronic anxiety?										
	Please explain:	_									
11.	Do emotional factors <i>contribute</i> to the severity of your patient's subjective symptoms and functional limitations? $\Box$ Yes $\Box$ No	l									
12.	Have your patient's impairments lasted or can they be expected to last at least twelve months?										
13.	As a result of your patient's impairments, estimate your patient's functional limitations if your patient were placed in a <i>competitive work situation</i> .										
	How many city blocks can your patient walk at one time before stopping?										
	Please circle the hours and/or minutes that your patient can sit <i>at one time</i> , <i>e.g.</i> , before needing to get up, <i>etc</i> .										
	Sit: 0 5 10 15 20 30 45										
	c. Please circle the hours and/or minutes that your patient can stand <i>at one time</i> , <i>e.g.</i> , before needing to sit down, walk around, <i>etc</i> .										
	Stand: 0 5 10 15 20 30 45										

working day (	with normal brea	aks):				
	Sit Sta	and/walk	less than 2 hours about 2 hours about 4 hours at least 6 hours			
e. Does your pats		nat permit	ts shifting positions	at will from sitting  Yes	g, □ No	
f. Will your patie	ent sometimes no	eed to tak	e unscheduled breal Yes	cs during a workin	g day?	
	) how <i>often</i> do y ) how <i>long</i> (on a have to rest bef	verage) v			<u> </u>	
g. With prolonge	ed sitting, should	your pati	ent's leg(s) be eleva	ted? ☐ Yes ☐	No	
If yes, 1	if your pat percentag	tient had a e of time	e leg(s) be elevated a sedentary job, <i>wha</i> during an 8-hour I the leg(s) be elevat	ut	<u>%</u>	
For this and other question means 6% to 33% of an 8-h h. How many po	our working day; '	'frequently		f an 8-hour working o	day.	
, , , , , , , , , , , , , , , , , , ,	J I.	Never		asionally Frequ		
Less tha 10 lbs. 20 lbs. 50 lbs.	an 10 lbs.					
i. State the degree	ee to which your	patient sl	hould avoid the follo	owing:		
ENVIRONMENTAL RESTRICTIONS Extreme cold Extreme heat High humidity Wetness Cigarette smoke Perfumes Soldering fluxes Solvents/cleaners Fumes, odors, gases Dust Chemicals List other irritants:	NO RESTRICTIO		AVOID CONCENTRATED EXPOSURE	AVOID EVEN MODERATE EXPOSURE	AVOID ALL EXPOSURE	
List other irritants:	П		П	П	П	

d. Please indicate how long your patient can sit and stand/walk total in an 8-hour

	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	5% or 1	more
	k.	Are y	your p	oatient	s's imp	airmeı	nts like	ely to p	oroduce	e "goo	d days' Yes	' and [	"bac ∃ N	d days lo	"?
	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 a result of the impairments or treatment:										n the ork as a				
					r t one d t two d					About	three d four da han fo	ays pe	er me	onth	nth
14.	der	nonst	rated	by sig	ns, cli	nical f	inding	s and l	aborate	ory or bed at		ults <i>r</i> this e	easo	<i>nably</i> aation'	rments) as consistent?
	If n	o, ple	ease e	xplair	n:										
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:										, dust,				
Date								Signar	ture						
				Pri	inted/T	yped l	Vame:								
				Add	dress:										
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8/09 §234.4															