

CARDIAC 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. Diagnosis (with New York Heart Association functional classification):

3. Prognosis: _____

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

5. Identify your patient's signs and symptoms:

- | | | |
|---|--|--|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Anginal equivalent pain | <input type="checkbox"/> Chronic fatigue |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Exercise intolerance | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Orthopnea | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Exertional dyspnea | <input type="checkbox"/> Rest dyspnea | <input type="checkbox"/> Nocturia |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Peripheral edema | <input type="checkbox"/> Pulmonary edema |
| <input type="checkbox"/> Syncope | <input type="checkbox"/> Near syncope | <input type="checkbox"/> Chronic cough |
| <input type="checkbox"/> Hepatomegaly | <input type="checkbox"/> Prinzmetal's angina | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Paroxysmal nocturnal dyspnea | | |

Other: _____

6. If your patient has angina:

a. Describe nature, location and radiation of symptoms: _____

b. How often do angina episodes typically occur? _____

c. If your patient must typically rest after an episode of angina, how long will your patient typically rest? _____

7. Describe the treatment and response including any side effects of medication that may have implications for working, *e.g.*, drowsiness, dizziness, nausea, etc:

8. a. What is the role of stress in bringing on your patient's symptoms?

- b. 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: _____

9. Do your patient's physical symptoms and limitations cause emotional difficulties such as depression or chronic anxiety? Yes No

Please explain: _____

10. Do emotional factors *contribute* to the severity of your patient's subjective symptoms and functional limitations? Yes No

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

12. 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 rest or severe pain? _____

- b. 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

- c. Does your patient need a job that permits shifting positions at will from sitting, standing or walking? Yes No

- d. 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? _____

- 3) on such a break, will your patient need to lie down or sit quietly?

e. 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? _____ %

3) what symptoms cause a need to elevate the leg(s)? _____

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.

f. 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"/>
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"/>

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

	Never	Rarely	Occasionally	Frequently
Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stoop (bend)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crouch/ squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb ladders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

h. 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"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

i. 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

j. 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

13. 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: _____

14. Please describe any other limitations (such as psychological limitations, limited vision, difficulty hearing, 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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