REFLEX SYMPATHETIC DYSTROPHY (RSD)/ COMPLEX REGIONAL PAIN SYNDROME, TYPE 1 (CRPS) 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 as appropriate.*

1. Frequency and length of contact: _____

2. Does your patient suffer from RSD/ CRPS? ☐ Yes ☐ No

   If yes, does your patient have persistent complaints of pain that are typically out of proportion to the severity of any documented precipitant?
   ☐ Yes ☐ No

   If yes, please identify which of the following clinically documented signs in the affected region have been present ***at any time*** following the documented precipitant:

   - ☐ Swelling
   - ☐ Decreased or increased sweating
   - ☐ Osteoporosis
   - ☐ Abnormal hair or nail growth – too slow or too fast
   - ☐ Changes in skin color or texture
   - ☐ Skin temperature changes
   - ☐ Abnormal pilomotor erection (gooseflesh)
   - ☐ Involuntary movements of the affected region

3. List any other diagnosed impairments: _____

4. Prognosis: _____

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

6. Identify your patient's symptoms and signs:

   - ☐ Burning, aching or searing pain initially localized to the site of injury
   - ☐ Increased sensitivity to touch
   - ☐ Joint stiffness
   - ☐ Restricted mobility
   - ☐ Muscle spasm
   - ☐ Impaired appetite
   - ☐ Pain complaints that spread to involve other extremities
   - ☐ Abnormal sensations of heat or cold
   - ☐ Muscle pain
   - ☐ Muscle atrophy
   - ☐ Impaired sleep
   - ☐ Chronic fatigue

   Other symptoms, signs and clinical findings: _____

7. Identify any associated psychological problems/ limitations:

☐ Cognitive limitations	☐ Personality change
☐ Impaired attention and concentration	☐ Depression
☐ Impaired short term memory	☐ Social withdrawal
☐ Reduced ability to attend to tasks	☐ Anxiety
☐ Reduced ability to persist in tasks	☐ List others in margin:

8. Identify ***side effects*** of any medications that may have implications for working:

☐ Drowsiness/ sedation ☐ Other: _____

9. 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 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 to include periods of walking around during an 8-hour working day? ☐ Yes ☐ No

If yes, how ***often*** must your patient walk? 1 5 10 15 20 30 45 60 90 (Minutes)

How ***long*** must your patient walk each time? 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 (Minutes)

g. 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) what symptoms cause a need for breaks?

☐ Muscle weakness ☐ Pain/ paresthesias, numbness
☐ Chronic fatigue ☐ Adverse effects of medication
☐ Other: _____

h. 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)? _____

i. While engaging in occasional standing/walking, must your patient use a cane or other hand-held assistive device? ☐ Yes ☐ No

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.

j 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.	☐	☐	☐	☐

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

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

l. If your patient has significant limitations with reaching, handling or fingering:

What symptoms cause limitations of use of the upper extremities?

☐ Pain/ paresthesias ☐ Motor loss ☐ Sensory loss/ numbness
☐ Muscle weakness ☐ Swelling ☐ Side effects of medication
☐ Limitation of motion ☐ Other: _____

Please indicate the percentage of time during an 8-hour working day that your patient can use hands/fingers/arms for the following activities:

	HANDS: Grasp, Turn Twist Objects	**FINGERS: Fine Manipulations**	**ARMS: Reaching In Front of Body**	**ARMS: Reaching Overhead**
Right:	**%**	**%**	**%**	**%**
Left:	**%**	**%**	**%**	**%**

m. 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

n. 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

o. 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

10. 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: _____

11. Please describe any other limitations (such as 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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