DIABETES MELLITUS MEDICAL SOURCE STATEMENT

From: _____

Re: _____(Name of Patient)

_____(Social Security No.)

Please answer the following questions concerning your patient's impairments. *Attach all relevant treatment notes, laboratory and test results as appropriate.*

1. Frequency and length of contact:_____

2. Diagnoses: _____

3. Prognosis: _____

4. Identify all of your patient's ***symptoms***:

☐ Fatigue	☐ General malaise	☐ Extremity pain and numbness
☐ Difficulty walking	☐ Muscle weakness	☐ Loss of manual dexterity
☐ Episodic vision blurriness	☐ Retinopathy	☐ Diarrhea
☐ Bladder infections	☐ Kidney problems	☐ Frequency of urination
☐ Bed wetting	☐ Hot flashes	☐ Sweating
☐ Infections/fevers	☐ Psychological problem	☐ Difficulty concentrating
☐ Excessive thirst	☐ Abdominal pain	☐ Headaches
☐ Rapid heart beat/chest pain	☐ Vascular disease/ leg cramping	☐ Dizziness/loss of balance
☐ Swelling		☐ Hypoglycemic attacks
☐ Chronic skin infections	☐ Insulin shock/coma	☐ Hypoglycemic unawareness
☐ Sensitivity to light, heat or cold	☐ Nausea/vomiting	☐ Other: _____ _____

5. Clinical findings: _____

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 ☐ Somatoform disorder ☐ Other: _____
☐ Anxiety ☐ Personality disorder

10. 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

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

2) 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? _____

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? _____

i. While engaging in occasional standing/walking, must your patient use a cane or other 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	☐	☐	☐	☐
Climb ladders	☐	☐	☐	☐
Climb stairs	☐	☐	☐	☐

l. If your patient has significant limitations with reaching, handling or fingering, 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. 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	☐	☐	☐	☐
Extreme heat	☐	☐	☐	☐
High humidity	☐	☐	☐	☐
Wetness	☐	☐	☐	☐
Cigarette smoke	☐	☐	☐	☐
Perfumes	☐	☐	☐	☐
Soldering fluxes	☐	☐	☐	☐
Solvents/cleaners	☐	☐	☐	☐
Fumes, odors, gases	☐	☐	☐	☐
Dust	☐	☐	☐	☐
Chemicals	☐	☐	☐	☐
List other irritants: _____	☐	☐	☐	☐

n. 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

o. 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: _____

p. 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

11. Are your patient's impairment's (physical impairments plus any emotional impairments) ***reasonably consistent*** with the symptoms and functional limitations described in this evaluation? ☐ Yes ☐ No

If no, please explain: _____

12. 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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