INTERSTITIAL CYSTITIS 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 Interstitial Cystitis? ☐ Yes ☐ No

3. Identify your patient's ***symptoms***:

   ☐ Urinary frequency ☐ Bladder/ pelvic pain ☐ Thigh pain
   ☐ Urinary urgency ☐ Low back pain ☐ Nocturia with disrupted sleep
   ☐ Anxiety ☐ Depression ☐ Daytime drowsiness & lack of mental clarity

   ☐ Other symptoms: _____

4. Identify the clinical findings and objective signs:

   ☐ Suprapubic tenderness on physical examination
   ☐ Hunner's ulcers on the bladder wall after hydrodistention on cystoscopy
   ☐ Glomerulations (pinpoint bleeding caused by recurrent irritation on the bladder wall) after hydrodistention on cystoscopy
   ☐ Absence of other disorders that could cause the symptoms

   ☐ Other findings: _____

5. Identify any associated disorders:

   ☐ Inflammatory bowel disease ☐ Allergies ☐ Fibromyalgia
   ☐ Chronic fatigue syndrome ☐ Irritable bowel syndrome ☐ Endometriosis
   ☐ Systemic lupus erythematosus ☐ Vulvodynia

6. Other diagnoses: _____

7. Prognosis: _____

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

_____

_____

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

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

11. Identify any psychological conditions affecting your patient's physical condition:

- ☐ Depression
- ☐ Somatoform disorder
- ☐ Psychological factors affecting physical condition
- ☐ Anxiety
- ☐ Personality disorder
- ☐ Other: _____

12. If your patient has urinary frequency, please estimate approximately how often your patient must urinate. _____

13. 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 stopping? _____

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 a job that permits ready access to a restroom?

☐ Yes ☐ No

g. Will your patient sometimes need to take unscheduled restroom breaks during a working day? ☐ Yes ☐ No

If yes, 1) how ***often*** do you think this will happen? _____

2) how ***long*** will your patient be away from the work station for an average unscheduled restroom break? _____

3) how much advance notice does your patient have of the need for a restroom break? _____

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.		☐	☐	☐
10 lbs.	☐	☐	☐	☐
20 lbs.	☐	☐	☐	☐
50 lbs.	☐	☐	☐	☐

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

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

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. To what degree can your patient tolerate work stress?

☐ Incapable of even "low stress" jobs ☐ Capable of low stress jobs
☐ Moderate stress is okay ☐ Capable of high stress work

Please explain the reasons for your conclusion: _____

l. Are your patient's impairments likely to produce "good days" and "bad days"?
☐ Yes ☐ No

If yes, assuming your patient is 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

16. 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:_____

17. Please describe any other limitations (such as limitations involving urinary incontinence, limitations using hands, arms, fingers, 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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