

LEUKEMIA
MEDICAL ASSESSMENT FORM

TO: Dr. _____

RE: _____

SSN: _____

Please answer all the following questions concerning your patient's leukemia and other health problems. *Attach all relevant treatment notes, laboratory and test results, which have not been provided previously to the Social Security Administration.*

1. Date began treatment: _____ Frequency of tx: _____

2. Does your patient exhibit leukemia? Yes No

A. If yes, please identify the type of leukemia:

CLL CLM ALL ANLL _____

B. Other diagnoses: _____

3. Prognosis: _____

4. Identify any **signs and symptoms** that your patient exhibits due to his/her impairments:

- | | | |
|--|--|--|
| <input type="checkbox"/> anorexia/weight loss | <input type="checkbox"/> weakness | <input type="checkbox"/> chronic headaches |
| <input type="checkbox"/> lower extremity edema | <input type="checkbox"/> easy bruisability | <input type="checkbox"/> dyspnea on exertion |
| <input type="checkbox"/> recurrent fevers | <input type="checkbox"/> bone/joint pain | <input type="checkbox"/> nausea/vomiting |
| <input type="checkbox"/> disturbed sleep | <input type="checkbox"/> pain/paresthesias | <input type="checkbox"/> progressive lymphoma |
| <input type="checkbox"/> granulocytopenia | <input type="checkbox"/> thrombocytopenia | <input type="checkbox"/> spontaneous hemorrhage |
| <input type="checkbox"/> chronic severe anemia | <input type="checkbox"/> irritability | <input type="checkbox"/> sense of abdominal fullness |
| <input type="checkbox"/> recurrent systemic bacterial infections | | |
| <input type="checkbox"/> persistent or relapsing debilitating fatigue/lethargy | | |
| <input type="checkbox"/> meningeal infiltration with increased intracranial pressure | | |
| <input type="checkbox"/> other: _____ | | |

5. Identify (or attach) positive clinical findings and test results (e.g., bone marrow, Epstein-Barr virus, cerebrospinal fluid examination, peripheral blood studies): _____

6. Does your patient experience symptoms which interfere with the **attention and concentration** needed to perform even simple work tasks, so that if your patient was working s/he would likely be **“off task” at least 15%** of the time? Yes No

E. Due to your patient's symptoms/treatment, should your patient **elevate leg(s)** at least two hours during a typical eight-hour daytime period? Yes No

If yes, how high should leg(s) typically be elevated:

- at or above heart level waist level
 between heart and waist level below waist level

F. How many pounds can the 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. If your patient has significant limitations with **reaching, handling or fingering**, please estimate the percentage of time during an eight-hour workday that your patient can use hands/fingers/arms for the following activities:

	HANDS: Grasp, Turn Twist Objects	FINGERS: Fine Manipulations	ARMS: Reaching (inc. Overhead)
<i>Right</i>	_____ %	_____ %	_____ %
<i>Left</i>	_____ %	_____ %	_____ %

H. Imagine that your patient was hired to perform competitive full-time work. Please estimate, on average, how often your patient would experience "bad days" so that your patient would be **absent** from work as a result of the impairment(s) or treatment:

- never/*less than once* a month about *four* days a month
 about *once or twice* a month *more than four* days a month
 about *three* days a month

Date: _____

Signed: _____

Print Name: _____

Address: _____