LUMBAR SPINE 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. Diagnoses: _____

_____

3. Prognosis: _____

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

_____

_____

_____

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

6. Identify all of your patient's ***symptoms***, including pain, insomnia, fatigue, etc.:

_____

_____

_____

7. If your patient has pain:

   a. Characterize the nature, location, radiation, frequency, precipitating factors, and severity of your patient's pain:

   _____

   _____

   _____

   b. Does your patient have neuro-anotomic distribution of pain?
   ☐ Yes ☐ No

c. Identify any positive objective signs:

☐ Reduced range of motion: Description _____

☐ Positive supine straight leg raising test:
Left at_____º Right at_____º

☐ Positive seated straight leg raising test

☐ Abnormal gait

☐ Sensory loss

☐ Reflex loss

☐ Tenderness

☐ Crepitus

☐ Swelling

☐ Muscle spasm

☐ Motor loss

☐ Muscle atrophy

☐ Muscle weakness

☐ Impaired appetite

☐ Weight change

☐ Impaired sleep

Other signs: _____

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

9. Identify the side effects of any medication that may have implications for working, e.g., dizziness, drowsiness, stomach upset, etc.:

_____

_____

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

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? _____

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. 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

Please explain the reasons for your conclusion: _____

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

If yes, assuming you 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 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: _____

12. Please add an additional page to describe any other limitations (such as 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: _____

_____