LYMPHEDEMA
MEDICAL ASSESSMENT FORM

TO: Dr._____

RE: _____
SSN: _____

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

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

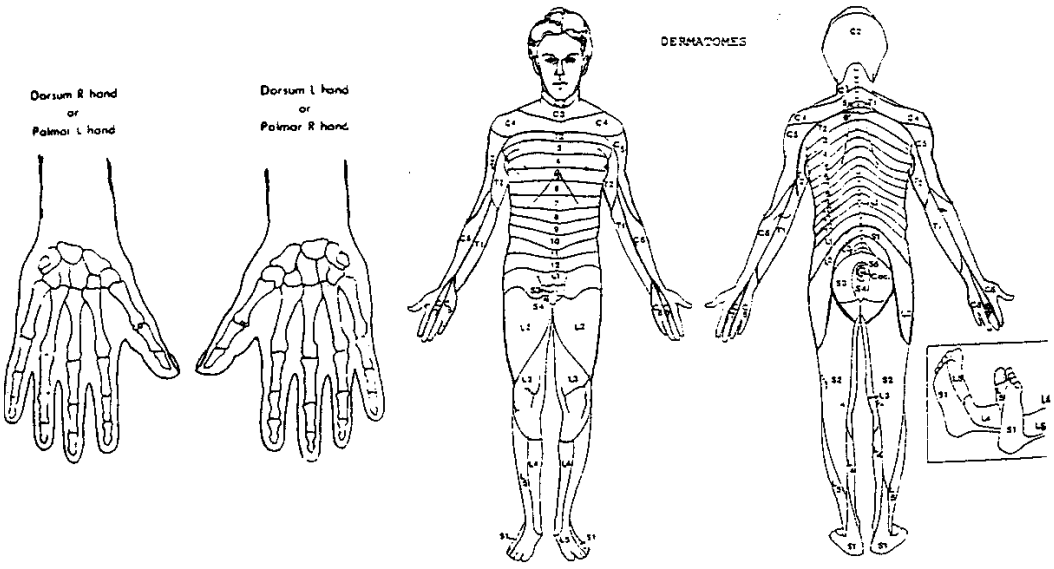
2. Does your patient exhibit lymphedema? ☐ Yes ☐ No
   Other diagnoses: _____

3. Please identify any **signs or symptoms** that your patient exhibits due to his/her impairments:
   ☐ chronic lower extremity edema ☐ chronic upper extremity edema ☐ chronic pain
   ☐ chronic fatigue ☐ paresthesia ☐ fibrosis ☐ other: _____
   _____

   If your patient exhibits chronic edema or pain/paresthesia,

   A. Characterize the nature and **severity** of the **pain/paresthesia**:
   ☐ mild ☐ moderate ☐ severe

   B. Identify the **location and frequency** of edema (E) or pain/paresthesia by shading the relevant body portions and labeling as constant (C), frequent (F), or intermittent (I):



4. Identify (or attach) any other positive clinical findings and test results (e.g., doppler, myelogram, MRI, CT scans, EMG/NCS): _____
_____
_____

5. 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

6. Identify any **side effects** of any medications which may have implications for working:
☐ drowsiness/sedation ☐ other: _____

7. As a result of your patient's impairment(s), estimate your patient's functional limitations assuming your patient was placed in a *competitive work situation* on an ongoing basis:

   A. How many city blocks can the patient **walk** without rest or severe pain? _____

   B. Please circle the hours and/or minutes that your patient can *continuously* **sit and stand** *at one time:*

   1. **Sit:** 0 5 10 15 20 30 45 (Minutes) 1 2, More than 2 (Hours)
   What must your patient usually do after sitting this long?
   ☐ walk ☐ stand ☐ lie down ☐ other: _____
   2. **Stand:** 0 5 10 20 30 45 (Minutes) 1 2, More than 2 (Hours)
   What must your patient usually do after standing this long?
   ☐ walk ☐ sit ☐ lie down ☐ other: _____

   C. Please indicate how long your patient can sit and stand/walk *total in an eight-hour workday* (with normal breaks)?

Sit	**Stand/Walk**	
☐	☐	less than 2 hours
☐	☐	about 2 hours
☐	☐	about 4 hours
☐	☐	at least 6 hours

   D. Due to your patient's impairment(s), if your patient will sometimes need to take unscheduled **breaks** (for at least several minutes duration) during an average eight-hour workday, **how many times** during an average workday do you expect this to happen?

   0 1 2 3 4 5 6 7 8 9 10, more than 10

   E. Due to your patient's symptoms, 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. While engaging in even occasional standing/walking must your patient use a **cane** or other assistive device for balance? ☐ Yes ☐ No

G. How many pounds can the patient **lift and carry** in a competitive work situation?

	Never	**Rarely**	**Occasionally**	**Frequently**
Less than 10 lbs.		☐	☐	☐
10 lbs.	☐	☐	☐	☐
20 lbs.	☐	☐	☐	☐
50 lbs.	☐	☐	☐	☐

H. How often can your patient perform the following waist-level activities?

	Never	**Rarely**	**Occasionally**	**Frequently**
Twist	☐	☐	☐	☐
Stoop (bend)	☐	☐	☐	☐

I. 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)**
Right	_____%	_____%	_____%
Left	_____%	_____%	_____%

J. 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

12. Please describe any other limitations that would affect your patient's ability to work at a regular job on a sustained basis or any testing that would help to clarify the severity of your patient's impairment(s) or limitations: _____
_____
_____
_____

Date: _____ Signed: _____

Print Name: _____