PULMONARY 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. Identify the clinical findings, laboratory and pulmonary function test results that show your patient's medical impairments: _____

_____

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

☐ Shortness of breath	☐ Rhonchi	☐ Episodic pneumonia
☐ Orthopnea	☐ Edema	☐ Fatigue
☐ Chest tightness	☐ Episodic acute asthma	☐ Palpitations
☐ Wheezing	☐ Episodic acute bronchitis	☐ Coughing

☐ Other symptoms: _____

_____

5. If your patient has acute asthma attacks,

   a. Identify the precipitating factors:

☐ Upper respiratory infection	☐ Emotional upset/stress
☐ Allergens	☐ Irritants
☐ Exercise	☐ Cold air/change in weather
☐ Aspirin/tartazine	☐ Foods

   b. Characterize the nature and severity of your patient's attacks: _____

   _____

   c. How often does your patient have asthma attacks? _____

   d. How long is your patient incapacitated during an average attack? _____

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

   If no, please explain: _____

7. a. List of prescribed medications:

b. Describe any side effects of your patient's medications (particularly of steroids, if applicable) that may have implications for working, e.g., dizziness, fatigue, drowsiness, stomach upset, etc.:

8. Prognosis: _____

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

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. How long can your patient 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. 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? _____

3) on such a break, will your patient need to ☐ lie down or ☐ sit quietly?

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.

f. 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.	☐	☐	☐	☐

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

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

h. 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: _____	☐	☐	☐	☐

i. 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

j. 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: _____

k. 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 impairments (physical impairments plus any emotional impairments) ***reasonably consistent*** with the symptoms and functional limitations described in this evaluation? ☐ Yes ☐ No

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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