STROKE 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. Did your patient have a stroke? ☐ Yes ☐ No

   If yes, type of stroke:________________________________

3. Other diagnoses:________________________________

4. Prognosis:________________________________

5. Identify all of your patient's symptoms:

   - ☐ Balance problems
   - ☐ Poor coordination
   - ☐ Loss of manual dexterity
   - ☐ Weakness
   - ☐ Slight paralysis
   - ☐ Unstable walking
   - ☐ Falling spells
   - ☐ Numbness or tingling
   - ☐ Other sensory disturbance
   - ☐ Pain
   - ☐ Fatigue
   - ☐ Bladder problems
   - ☐ Nausea
   - ☐ Vertigo/dizziness
   - ☐ Headaches
   - ☐ Difficulty remembering
   - ☐ Confusion
   - ☐ Depression
   - ☐ Emotional lability
   - ☐ Personality change
   - ☐ Difficulty solving problems
   - ☐ Problems with judgment
   - ☐ Double or blurred vision
   - ☐ Partial or complete blindness
   - ☐ Shaking tremor
   - ☐ Speech/communication difficulties
   - ☐ Other:________________________________

6. Clinical findings:________________________________

   ____

7. Does your patient have significant and persistent disorganization of motor function in two extremities resulting in sustained disturbance of gross and dexterous movement or gait and station? ☐ Yes ☐ No

   If yes, please describe the degree of interference with locomotion and/or interference with the use of fingers, hands and arms:________________________________

   ____

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

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? __________________

    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. 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?

    g. 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? __________________%

    h. 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.

i. 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.	☐	☐	☐	☐

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

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

k. Does your patient have significant limitations with reaching, handling or fingering?
☐ Yes ☐ No

If yes, 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:	**%**	**%**	**%**	**%**

l. 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	☐	☐	☐	☐
Fumes, odors, gases	☐	☐	☐	☐
Soldering fluxes	☐	☐	☐	☐
Dust	☐	☐	☐	☐
Hazards (heights, etc.)	☐	☐	☐	☐

m. 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: ________________________________

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n. 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

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

If yes, assuming your patient was trying to work, 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 three days per month
☐ About one day per month ☐ About four days per month
☐ About two 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 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:

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______________________________ ______________________________
Date *Signature*

Printed/Typed Name: ______________________________

Address: ______________________________

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