TREATING MEDICAL SOURCE STATEMENT
MEDICAL OPINION RE:
ABILITY TO DO WORK-RELATED ACTIVITIES (PHYSICAL)

NAME: ________________________SSN: ______________________________________

To determine your patient's ability to do *work-related activities on a day-to-day basis in a regular work setting*, please give us your opinion -- **based on your examination** -- of how your patient's physical capabilities are affected *by the impairment(s).* Do not consider your patient's age, sex or work experience. Consider the medical history, the chronicity of findings (or lack thereof), symptoms *(including differing individual tolerances for pain, etc.)*, and the expected duration of any work-related limitations.

For each activity shown below:

(1) Indicate your patient's ability to perform the activity; and

(2) Identify the particular medical findings (e.g., physical examination findings, x-ray findings, laboratory test results, history, symptoms (including pain), etc.) which support your opinion regarding any limitations.

IT IS IMPORTANT THAT YOU RELATE PARTICULAR MEDICAL FINDINGS TO ANY REDUCTION IN CAPACITY; THE USEFULNESS OF YOUR OPINION DEPENDS ON THE EXTENT TO WHICH YOU DO THIS.

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1. Maximum ability to lift and carry on an *occasional* basis (no more than 1/3 of an 8-hour day).

   No limitation 100# 50# 20# 10# less than 10#

2. Maximum ability to lift and carry on a *frequent* basis (1/3 to 2/3 of an 8-hour day).

   No limitation 50# 25# 10# less than 10#

3. Maximum ability to stand and walk (with normal breaks) during an 8-hour day.

   No limit about 6 hrs. about 4 hrs. about 3 hrs. about 2 hrs. less than 2 hrs.

4. Maximum ability to sit (with normal breaks) during an 8-hour day.

   No limit about 6 hrs. about 4 hrs. about 3 hrs. about 2 hrs. less than 2 hrs.

   While sitting, should the patient elevate his/her leg(s)? ☐ Yes ☐ No

   If Yes, how high should the patient elevate his/her leg(s)? ___________

5. If your patient must periodically alternate sitting, standing or walking to relieve discomfort:

   How long can your patient ***sit*** before changing position?

   0 5 10 15 20 30 45 60 90 Minutes

How long can your patient ***stand*** before changing position?

0 5 10 15 20 30 45 60 90
Minutes

How ***often*** must your patient ***walk around***? Frequency:

0 5 10 15 20 30 45 60 90
Minutes

How ***long*** must your patient ***walk each time***? Duration:

0 5 10 15 20 30 45 60 90
Minutes

Does your patient need the opportunity to shift ***at will*** from sitting or standing/walking?

Yes No

6. Will your patient sometimes need to lie down at unpredictable intervals during a work shift?

Yes No

If yes, how often do you think this will happen? ___________________________________

7. **What medical findings support the limitations described above?**

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____

8. How often can your patient perform the following *postural activities*? What medical findings support this?

	Frequently	*Occasionally	**Never
Twist			
Stoop (bend)			
Crouch			
Climb stairs			
Climb ladders			

*Frequently: from 1/3 to 2/3 of an 8-hour day
**Occasionally: from very little up to 1/3 of an 8 hour day

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9. Are the following *Physical Functions* affected by the impairment?

Reaching (including overhead) Yes No
Handling (gross manipulation) Yes No
Fingering (fine manipulation) Yes No
Feeling Yes No
Pushing/pulling Yes No

*. If yes, how are these physical functions affected and what medical findings support this?
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____
____

10. ENVIRONMENTAL RESTRICTIONS:	NO RESTRICTION	AVOID CONCENTRATED EXPOSURE	AVOID EVEN MODERATE EXPOSURE	AVOID ALL EXPOSURE
Extreme cold				
Extreme heat				
Wetness				
Humidity				
Noise				
Fumes, odors, dusts, gases, poor ventilation, etc.				
Hazards (machinery, heights, etc.)				

Describe how these environmental factors impair activities and identify hazards to be avoided. **Also explain what medical findings support these limitations.**

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11. State any other work-related activities which are affected by the impairment such as need for assistive device for ambulation, need to elevate leg, limits on kneeling, crawling, balancing, seeing, hearing or speaking, or limitations related to a mental impairment. What medical findings support this? **Are there any side effects from medication? If so, please identify what, if any, side effects there are.**

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12. On the average, how often do you anticipate that your patient's impairments or treatment would cause your patient to be absent from work?

___ Never ___ About once a month ___ About three times a month
___ Less than once a month ___ About twice a month ___More than three times a month

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13. What is the **earliest date** on which the above restrictions apply?

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____________________________ ____

Date Physician's Signature
§221.7

Printed/Typed Name: __________________________________

Address: __________________________________