

PHYSICIAN'S STATEMENT OR OPINION ABOUT PATIENT/CLAIMANT

NAME OF PATIENT/CLAIMANT:

SSN:

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| 1. <input type="checkbox"/> SOCIAL SECURITY CASE | <input type="checkbox"/> WORKERS COMPENSATION CASE | <input type="checkbox"/> VETERANS CASE |
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| 2. <u>Relationship to Patient/Claimant named above:</u> | <input type="checkbox"/> Treating Medical Source | <input type="checkbox"/> Consulting |
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| 3. <u>Diagnosis:</u> (1) | <input type="checkbox"/> Treating Medical Source | <input type="checkbox"/> Consulting |
| (2) | <input type="checkbox"/> Treating Medical Source | <input type="checkbox"/> Consulting |
| (3) | <input type="checkbox"/> Treating Medical Source | <input type="checkbox"/> Consulting |
| (4) | <input type="checkbox"/> Treating Medical Source | <input type="checkbox"/> Consulting |
| (5) | <input type="checkbox"/> Treating Medical Source | <input type="checkbox"/> Consulting |
| (6) | <input type="checkbox"/> Treating Medical Source | <input type="checkbox"/> Consulting |
| (7) | <input type="checkbox"/> Treating Medical Source | <input type="checkbox"/> Consulting |
| (8) | <input type="checkbox"/> Treating Medical Source | <input type="checkbox"/> Consulting |
| (9) | <input type="checkbox"/> Treating Medical Source | <input type="checkbox"/> Consulting |
| (10) | <input type="checkbox"/> Treating Medical Source | <input type="checkbox"/> Consulting |

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| 4. <u>Objective Sources or Tests used in Diagnosis:</u> | (SSR 96-2p) |
| <u>Musculoskeletal</u> <input type="checkbox"/> Radiology <input type="checkbox"/> MRI <input type="checkbox"/> CT Scan <input type="checkbox"/> Other Imagery: _____ | <input type="checkbox"/> Positive Serologic <input type="checkbox"/> Elevated Sedimentation <input type="checkbox"/> Antinuclear antibodies |
| <u>Respiratory</u> <input type="checkbox"/> Pulmonary Function | |
| <u>Cardiovascular</u> <input type="checkbox"/> Stress Electrocardiogram <input type="checkbox"/> ECG <input type="checkbox"/> EKG <input type="checkbox"/> Angiogram | |
| <u>Digestive</u> <input type="checkbox"/> Endoscopy <input type="checkbox"/> Ultrasonography <input type="checkbox"/> Other Imagery: _____ <input type="checkbox"/> Upper GI Series | |
| <u>Genito-Urinary</u> <input type="checkbox"/> Serum Chemistry <input type="checkbox"/> Urinalysis <input type="checkbox"/> Renal Function Measurement | |
| <u>Hemic/Lymphatic</u> <input type="checkbox"/> Pathology Testing <input type="checkbox"/> Blood Testing <input type="checkbox"/> Platelet Count <input type="checkbox"/> Serum/Urine Tests <input type="checkbox"/> Serum/Calcium | |
| <u>Skin</u> <input type="checkbox"/> Neutrophil Counts <input type="checkbox"/> Tissue Biopsy <input type="checkbox"/> Smear Testing <input type="checkbox"/> Tissue Biopsy <input type="checkbox"/> Immunofluorescence Testing <input type="checkbox"/> Patch Tests | |
| <u>Endocrine</u> <input type="checkbox"/> Blood, Urine or Spinal Fluid Testing <input type="checkbox"/> Lab Tests <input type="checkbox"/> Hyperthyroid Testing <input type="checkbox"/> Diabetes Testing <input type="checkbox"/> Diabetes Mellitus Testing | |
| <u>Multiple Body</u> <input type="checkbox"/> Biopsy <input type="checkbox"/> Hypertension | |
| <u>Neurological</u> <input type="checkbox"/> Electroencephalography <input type="checkbox"/> Nerve Conduction Studies <input type="checkbox"/> Electromyography | |
| <u>Mental Health</u> <input type="checkbox"/> Electroradiologic <input type="checkbox"/> Neurochemical <input type="checkbox"/> Neuropathologic | |
| <u>Neoplastic Malignant</u> <input type="checkbox"/> MMPI-II <input type="checkbox"/> Wechsler's <input type="checkbox"/> Zung Depression <input type="checkbox"/> Purdue Pegboard <input type="checkbox"/> Bender Motor-Gestalt | |
| <input type="checkbox"/> Beck Depression <input type="checkbox"/> Whitaker Index <input type="checkbox"/> Halstead-Reitan | |
| <u>Other Objective Testing:</u> _____ | |

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| 5. Your Opinion: Do your clinical and laboratory findings support your diagnosis? | (SSR 96-2p) |
| | <input type="checkbox"/> Yes, with substantial evidence |
| | <input type="checkbox"/> Yes, Not inconsistent |
| | <input type="checkbox"/> No, but still adequate for medical opinion |

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| 6. Your Opinion: Do the functionally limiting effects of the diagnosis have more than a minimal effect on the ability to do basic work activities <u>and</u> are these limiting effects considered "severe" or "reasonably expected to be severe"? | (SSR96-3p) |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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| 7. Your Opinion: Can your diagnosis reasonably be expected to produce: (Check if "Yes") | (SSR96-4p) |
| | <input type="checkbox"/> Exertional Limitations in basic work activities (such as sitting, standing, walking, lifting, carrying, pushing and pulling) |
| | <input type="checkbox"/> Non-Exertional Limitations in basic work activities (such as pace and persistence limitations or mental limitations) |

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| 8. Your Opinion: Does the Patient/Claimant <u>meet</u> or <u>equal</u> those Listings (as defined in Federal Regulations) related to your diagnosis? | |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| This Listing is attached and is identified as Listing _____ (Please leave Listing attached) | |
| Please explain or offer any other information: | |

| | |
|--------------------|---------------------------|
| 9. PHYSICIAN NAME: | 10. SIGNATURE: |
| 11. ADDRESS: | 12. TELEPHONE: DATE: |

PATIENT/CLAIMANT'S WORK RESTRICTIONS

NAME OF PATIENT/CLAIMANT:

SSN:

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|---|--|--|
| <input type="checkbox"/> SOCIAL SECURITY CASE | <input type="checkbox"/> WORKERS COMPENSATION CASE | <input type="checkbox"/> VETERANS CASE |
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2. Check the frequency and number of hours per day the claimant is able to do the following:

| ACTIVITY | CONTINUOUS | INTERMITTENT | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|--------------|------------|--------------|---|---|---|---|---|---|---|---|
| A. SITTING | | | | | | | | | | |
| B. WALKING | | | | | | | | | | |
| C. STANDING | | | | | | | | | | |
| D. BENDING | | | | | | | | | | |
| E. SQUATTING | | | | | | | | | | |
| F. CLIMBING | | | | | | | | | | |
| G. KNEELING | | | | | | | | | | |
| H. TWISTING | | | | | | | | | | |
| I. LIFTING | | | | | | | | | | |
| J. CRAWLING | | | | | | | | | | |
| K. HAND USE | | | | | | | | | | |

3. Check SUSTAINED OR CONTINUOUS STANDARD WORKING CONDITION lifting restrictions:
 0 - 10 lbs 11 - 20 lbs 21 - 50 lbs 51 - 75 lbs 76+ lbs

4. Does Claimant have HAND or ARM RESTRICTIONS? YES NO
 If "YES", indicate Restriction type: Simple Grasping; Pushing and Pulling; Fine Manipulation;
 Repetitive Movement/ Production Work

5. Does Claimant have LEG or FOOT RESTRICTIONS? YES NO
 If "YES", indicate Restriction type: Normal Walking; Pushing and Pulling Leg Controls;
 Operation of Machinery or Vehicle Repetitive Movement Cane or Crutch suggested

6. Does Claimant have BACK RESTRICTIONS? YES NO
 If "YES", indicate Restriction type: Normal Walking; Sitting without Breaks at will;
 Standing/Sitting Without Breaks at Will; Riding in or Driving Machinery/Vehicles;
 Operation of Machinery or Vehicle Repetitive Movement Work involving Vibration

7. The Claimant HAS restrictions concerning: Ability to ride/commute in vehicle more than 20-30 minutes
 Heat/Cold, humidity, dampness High Speed/Production Work Exposure to Dust, Fumes or Gas
 Cardiac Condition/Stress Visual Senses Hearing Condition Stress Condition
 Cognitive Deficits Chronic Pain

8. Are Interpersonal Relations adversely effected by Claimant's restrictions? YES NO If "YES",
 indicate type: Appropriate response to Coworkers Irritability Withdrawal Anxiety Ability to
 respond to simple instructions and supervision Depression Medication side effects
 Other:

9. Can the Claimant work EIGHT hours per day? YES NO
 If not eight hours, how many and when?

10. Should the Claimant take breaks/rest periods as the claimant deems necessary? YES NO

11. Does the Claimant have Chronic Pain? YES NO
 What part of the body has chronic pain?

12. Has Claimant reached maximum medical improvement? YES (Indicate when):
 NO (Estimate when):

13. Do you recommend Vocational Rehabilitation before claimant returns to work? YES NO

RECOMMENDED FUTURE TREATMENT/SURGERY:

14. NAME: 15. SIGNATURE:

16. ADDRESS: 17. TELEPHONE: 18. DATE: