

**MEDICAL SOURCE STATEMENT OF
ABILITY TO DO WORK-RELATED ACTIVITIES (PHYSICAL)**

NAME OF INDIVIDUAL _____

SOCIAL SECURITY NUMBER _____

To assist in determining your patient's ability to do work-related activities, please give us your professional opinion of what he / she can still do despite his/her impairment(s). The opinion should be based on your medical findings, including history, clinical and laboratory findings, diagnosis, prescribed treatment and response, expected duration and prognosis. **IT IS VERY IMPORTANT TO DESCRIBE THE FACTORS THAT SUPPORT YOUR ASSESSMENT.**

Patient is able to **STAND and/or WALK**

- less than 2 hours** in an 8-hour workday (if less than 2 hours, provide explanation of this limitation below)
- at least 2 hours but less than 6 hours** in an 8-hour workday
- 6 hours** in an 8-hour workday

Patient is able to **SIT**

- less than 2 hours** in an 8 hour workday (if less than 2 hours, please provide explanation)
- at least 2 hours but less than 6 hours** in an 8-hour workday
- 6 hours** in an 8-hour workday

What **medical/clinical finding(s)** support your conclusions in items above?

Additional restrictions?

- medically required hand-held device necessary for ambulation:
(Please circle) Cane, walker, crutches, brace, other _____
- difficulties with uneven ground
- must periodically alternate sitting and standing to relieve pain or discomfort
- frequent breaks _____ times per hour for _____ minutes: (circle one) scheduled / as needed
- must elevate legs _____ times per day for _____ minutes: (circle one) scheduled / as needed
- must lie down _____ times per day for _____ minutes: (circle one) scheduled / as needed

Patient is able to **LIFT/CARRY**

Frequently (1/3 to 2/3 of 8 hr day, cumulative, not continuous)

Occasionally (less than 1/3 of 8 hr day)

- | | |
|--|--|
| <input type="checkbox"/> less than 10 pounds | <input type="checkbox"/> less than 10 pounds |
| <input type="checkbox"/> 10 pounds | <input type="checkbox"/> 10 pounds |
| <input type="checkbox"/> 20 pounds | <input type="checkbox"/> 20 pounds |
| <input type="checkbox"/> 50 pounds | <input type="checkbox"/> 50 pounds |

POSTURAL LIMITATIONS

	Frequently (1/3 of 8 hr day)	Occasionally (less than 1/3)	Never
Climbing—ramps/stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What **medical/clinical findings** support your conclusion?

MANIPULATIVE LIMITATIONS

- Reaching all directions (including overhead) Dominant / Non-dominant (circle one)
- Handling (grasp, manipulation, pinching) Dominant / Non-dominant (circle one)
- Feeling (skin receptors) Dominant / Non-dominant (circle one)
- Fingering of Dominant hand / wrist
 - Fine manipulative
 - Rapid movements Fatigue with repetitive use
- Fingering of Non-dominant hand / wrist
 - Fine manipulative
 - Rapid movements Fatigue with repetitive use

What **medical/clinical findings** support your conclusion?

VISUAL COMMUNICATIVE LIMITATIONS

YES NO

- Seeing Explain: _____
- Hearing Explain: _____
- Speaking Explain: _____

ENVIRONMENTAL LIMITATIONS

YES NO

- Temperature Extremes
- Noise
- Dust
- Vibration
- Humidity/Wetness
- Hazards (machinery, heights...)
- Fumes, odors, chemicals, gases

What **medical/clinical findings** support your conclusion?

Comments: _____

Signature of Physician: _____ **Date:** _____

Printed Name of Physician: _____

Signature of Counselor / Social Worker / Therapist / Other: _____

Printed name: _____ Date: _____

Please note that the Treating Physician Rule only applies if the forms are signed by an M.D. If this form is completed by a counselor, social worker, RN, APRN, or PA, it must be cosigned by a physician.