TREATING SOURCE STATEMENT OF
ABILITY TO DO WORK RELATED ACTIVITIES (PHYSICAL)

NAME OF INDIVIDUAL SOCIAL SECURITY NUMBER

Please answer the following questions regarding your patient's impairments.

1. Nature, frequency and length of contact:_____

2. Diagnoses:_____

_____

3. Identify the clinical findings, laboratory and test results which confirm your patient's medical impairments:

_____

_____

_____

4. Identify all your patient's symptoms, including pain, dizziness, fatigue, etc.:

_____

_____

5. If your patient has pain, characterize the nature, location, radiation, frequency, precipitating factors and severity of your patient's pain (i.e. Frequent, 8/10 burning pain in low back, radiating to RLE brought on by any activity)

_____

_____

6. What objective signs support your patient's pain?_____

_____

_____

7. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations?

☐ Yes ☐ No

8. During an 8 hour work day, how often is your patient going to experience symptoms severe enough to interfere with attention and concentration?

☐ Never ☐ 5% of the time ☐ 10% of the time ☐ 20% of the time ☐ more than 20% of the time

9. Does your patient take any medication(s) that you prescribe, which impair's their ability to work a full eight (8) hours day with only routine breaks? ☐ Yes ☐ No

If yes, please list the medications and their effects (i.e. lasix and urinary frequency; hydrocodone and drowsiness)

Medication:_____ Side effect:_____
Medication:_____ Side effect:_____
Medication:_____ Side effect:_____

10. Have your patient's impairments lasted or can the be expected to last 12 months?

☐ Yes ☐ No

To determine the your patient's ability to perform work activities 8 hours a day, 5 days a week, please give your opinion about each activity below:

- **OCCASIONALLY** (Occ.) means very little to one-third of the day.
- **FREQUENTLY** (Freq.) means one-third to two-thirds of the day.
- **CONTINUOUSLY** (Cont.) means more than two-thirds of the time.

I. LIFTING/CARRYING

Check the boxes representing the amount your patient can **lift** and how often.

Lift	Never	Occasionally	Frequently	Continuously
Up to 10 lbs.				
11 to 20 lbs.				
21 to 50 lbs.				
51 to 100 lbs.				

Check the boxes representing the amount your patient can **carry** and how often.

Carry	Never	Occasionally	Frequently	Continuously
Up to 10 lbs.				
11 to 20 lbs.				
21 to 50 lbs.				
51 to 100 lbs.				

II. SITTING/STANDING/WALKING

Please check how many hours, or if less than an hour how many minutes your patient can:

AT ONE TIME, without interruption

	Minutes	Hours							
A. Sit	_____	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
B. Stand	_____	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
C. Walk	_____	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8

TOTAL in an 8 hour work day.

PHYSICIANS PLEASE NOTE: The total for sitting, standing, walking should total 8 hours. If your patient would need to recline or lay down outside of the customary two 15 minute breaks and lunch hour, please note it below.

	Minutes	Hours							
A. Sit	_____	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
B. Stand	_____	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
C. Walk	_____	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
D. Laying/ Recline	_____	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8

UNSCHEDULED BREAKS. If your patient would simply require unscheduled breaks during a normal work day, please indicate how often a break would be required, and for how long:

Break every: (circle one) 30 minutes 1 Hour 2 Hours Other:_____

Break lasts: (circle one) 1 minute 5 minutes 10 min. Other:_____

USE OF CANE. Does your patient require the use of a cane to ambulate? ☐ Yes ☐ No

- How far can your patient ambulate without a cane? _____
- Is the use of a cane medically necessary? ☐ Yes ☐ No

III. USE OF HANDS

Indicate how often your patient can perform the following activities:

ACTIVITY	Right Hand					Left Hand			
	Never	Occasionally	Freq.	Cont.		Never	Occasionally	Freq.	Cont.
REACHING (Overhead)									
REACHING (All Other)									
HANDLING									
FINGERING									
FEELING									
PUSH/PULL									

Which is your patient's dominant hand? ☐ Right Hand ☐ Left Hand

IV. USE OF FEET

Indicate how often your patient can perform the following activities:

ACTIVITY	Right Foot					Left Foot			
	Never	Occasionally	Freq.	Cont.		Never	Occasionally	Freq.	Cont.
Operation of Foot Controls									

NEUROPATHIC PAIN- If your patient has neuropathic pain, do any of the following work restrictions apply?

☐ N/A ☐ Limited standing/walking ☐ Limited gross/fine manipulation ☐ Other:_____

ELEVATION OF LEGS - Does your patient need to elevate their legs during their normal workday?

☐ Yes ☐ No If yes, should the legs be elevated above the heart? ☐ Yes ☐ No

What percentage of the day should the legs be elevated? _____%
What is the basic reason for elevating the legs? ☐ Swelling ☐ Avoid clots ☐ Other:_____

V. POSTURAL ACTIVITIES

How often can your patient perform the following activities?

ACTIVITY	Never	Occasionally	Frequently	Continuously
Climb stairs and ramps				
Climb ladders or scaffolds				
Balance				
Stoop				
Kneel				
Crouch				
Crawl				

VI. DEFICITS IN HEARING OR VISION

Does your patient have any deficit in hearing or vision? ☐ Yes ☐ No ☐ Not Evaluated

1. If a **hearing impairment** is present,

   a. Does your patient retain the ability to hear and understand simple oral instructions and to communicate simple information? ☐ Yes ☐ No
   b. Can your patient use a phone to communicate? ☐ Yes ☐ No

2. If a **visual impairment** is present,

   a. Is your patient able to avoid ordinary hazards in the workplace, such as boxes on the floor, doors ajar, or approaching people or vehicles? ☐ Yes ☐ No

   b. Is your patient able to read very small print? ☐ Yes ☐ No

   c. Can your patient able to read newspaper or book print? ☐ Yes ☐ No

   d. Can your patient read a computer screen? ☐ Yes ☐ No

   e. Is there a limit to how long your patient can read from a computer screen? ☐ Yes ☐ No

      If yes, what is that limit?_____

   f. Is your patient able to determine differences in shape and color of small objects such as screws, nuts or bolts? ☐ Yes ☐ No

VII. ENVIRONMENTAL LIMITATIONS

How often can your patient tolerate exposure to the following conditions:

Condition	Never	Occasionally	Frequently	Continuously
Unprotected Heights				
Moving Mechanical parts				
Operating a car/equipment				
Humidity and wetness				
Dust, odors, pulmonary irritants				
Extreme cold				
Extreme heat				
Vibrations				
Others:_____				

VIII. SPECIAL CIRCUMSTANCES

a. Would you patient have difficulty performing production or quota work, where work pace is critical?

☐ Yes ☐ No Would your patient have to work at a slower pace? ☐ Yes ☐ No

b. Would your patient be physically capable of fulfilling the physical requirements of an 8 hour work day and a 40 hour workweek on a consistent basis? ☐ Yes ☐ No

c. On average, how often do you anticipate your patient's impairments or treatment would cause them 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

_____ _____
Physician's signature Date

_____
Printed name

_____
Address

_____ Physician stamps are acceptable