INSTRUCTIONS FOR THE
PHYSICAL HEALTH
MEDICAL SOURCE STATEMENT FORM

1. **Do not** write on this form yourself.

2. Take this form to the medical source that knows the most about all of your conditions.

3. You should not be in the room when the medical source fills it out and you should not directly answer the questions on the form for the medical source. The medical source needs to complete the form **independently** of you.

4. A **MD, DO, APRN or PA *must*** sign this form in order for it to be accepted by Social Security.

5. We cannot force your medical source to complete the report.

6. You may return this report to us or the medical source may return the report by fax to 702-800-5408.

PROFESSIONAL ADVOCATES, INC.
Social Security Disability Representation

415 S. 6th St. Suite 319 ★ Las Vegas, NV. 89101
O. 702-518-6672 F. 702-800-5408

REQUEST FOR REPORT

Your patient has a disability claim pending before the Social Security Administration and the Professional Advocates, Inc. is representing your patient. You may return the attached report to us via fax at 702-800-5408.

The attached report requests your medical opinion about the maximum residual functional capacity of your patient. **Please do not refer your patient to a physical therapist or recommend a functional capacity examination for the purposes of completing the report.** A report from a functional capacity examination will carry very little weight since this is a one-time exam and it is not an opinion by you, the treating medical source. ***YOU WILL NOT BE CALLED TO TESTIFY IN COURT.***

Please answer any of the questions you can. Some information can be more helpful than you think. Please be sure to complete the question "What medical findings support this opinion?"

You do not have to render an opinion about whether the patient is disabled. The Administration's definition of a medical opinion is what an individual can still do, despite their severe impairment. *Whether the patient is disabled is Social Security's decision.*

However, you *are* the medical professional most able to provide a detailed, longitudinal picture of a claimant's medical impairments. You bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings, reports of individual examinations, or from one time consultative examinations arranged by Social Security. Your opinion is given special consideration.

If you have any questions or concerns regarding this report you may contact me directly at 702-518-6672. Thank you for your gracious consideration of this request.

PROFESSIONAL ADVOCATES, INC.

TREATING PHYSICIAN MEDICAL SOURCE STATEMENT

Patient Name:	SSN:
Diagnosis:	DOB:

Based on your examination of this claimant, would you state your professional opinion as to her/his ability to perform the following functions in a given **eight hour work day**:

1. Total Hours Sitting in an 8 hr day

   1 2 3 4 5 6 7 8

   How many minutes at a time? _____ min

What medical findings support this assessment?

2. Total Hours Standing/Walking in an 8 hr day

   1 2 3 4 5 6 7 8

   How many minutes at a time? _____ min

What medical findings support this assessment?

3. Lifting / Carry in an 8 hr day

Maximum Occasionally: _____pounds
Maximum Frequently: _____pounds

What medical findings support this assessment?

4. With prolonged sitting, should your patient's leg(s) be elevated? ( ) Yes ( ) No

5. Is this patient a malingerer? ( ) Yes ( ) No

6. Postural Capacity: Is the patient able to do the following:

	Frequently	Occasionally	Never
a. Climbing ramp/stairs	_____	_____	_____
b. Climbing ladder/scaffolds	_____	_____	_____
c. Balancing	_____	_____	_____
d. Stooping/Bending	_____	_____	_____
e. Kneeling	_____	_____	_____
f. Crouching/Squatting	_____	_____	_____

7. If your patient has significant limitations with **reaching, handling or fingering,** What symptom(s) cause limitations with use of the upper extremities?

☐ pain/paresthesia ☐ motor loss ☐ sensory loss/numbness
☐ swelling ☐ muscle weakness ☐ side effects of medication
☐ limitation of motion ☐ other: _____

Please estimate the percentage of time during an eight-hour workday that your patient can use hands/fingers/arms for the following activities:

	HANDS: Grasp, Turn Twist Objects	**FINGERS: Fine Manipulations**	**ARMS: Reaching (inc. Overhead)**
Right	_____%	_____%	_____%
Left	_____%	_____%	_____%

8. Is an assistive device (cane, crutch) medically necessary for ambulation?

( ) No ( ) Not needed for short distance on level surface

( ) Yes If yes: ( ) Essential to ambulate ( ) only to get up and down

For the following questions, please assume your patient is ATTEMPTING to work 8 hours a day, 5 days a week:

9. Would your patient need to take unscheduled breaks during an 8 hour period? ( ) Yes ( ) No
How often will this happen? ( ) Once ( ) Twice ( ) More than Twice

How long would your patient have to take this break before returning to work? _____ min / hr

10. Are your patient's impairments likely to produce "good days" and "bad days"? ( ) Yes ( ) No

If yes, please estimate, on the average, how many days per month your patient would be likely to be absent from work as a result of the impairments or treatment:

__ Never
__ About one day per month
__ About two days per month
__ About three days per month
__ About four days per month
__ More than four days per month

11. Are there any symptoms that would prevent your patient from concentrating for more than a total of 2 hours in an 8 hour day? ( ) Yes ( ) No

If yes, what are those symptoms? (ex: pain, fatigue, side effects of medication, etc.)

12. Are all of these limitations expected to last for 12 months or longer? ( ) Yes ( ) No

13. What month and year did the restrictions as you have opined begin? Month:_____ Year:_____

14. When did you first treat this patient? Month:_____ Year:_____

Comments regarding any other factors which impact your patient's ability to function.

DATED: _____

_____
M.D. SIGNATURE

MD Printed Name, Address & Phone No.
(Please write or stamp the MD information so we have legible identification of the signature.)**

* This form was provided by Representative in blank to the medical provider or claimant without comment as to how the form should be completed and no suggestion as to answers for the form was given to either the medical provider or claimant. The claimant was not referred to this provider by the Representative. [20 CFR § 404.1740(b)(5) & 416.1540(b)(5)]

PROFESSIONAL ADVOCATES, INC