

***CARDIAC MEDICAL SOURCE STATEMENT***

From: \_\_\_\_\_

Re: \_\_\_\_\_ (Name of Patient)

\_\_\_\_\_ (Social Security No.)

Please answer the following questions concerning your patient's impairments. *Refer to relevant treatment notes, radiologist reports, laboratory, and test results as appropriate.*

1. Frequency and length of contact: \_\_\_\_\_

2. Diagnoses: \_\_\_\_\_

3. Prognosis: \_\_\_\_\_

4. What tests or observations were used to determine your patient's diagnoses?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. If you patient has angina, how often do these episodes typically occur? \_\_\_\_\_

How long must your patient typically rest after an episode of angina? \_\_\_\_\_

6. List your patient's *symptoms*, including pain, dizziness, fatigue, etc:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. What is the role of stress in bringing on your patient's symptoms? \_\_\_\_\_

How well can your patient tolerate work stress? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. How do these symptoms / impairments interfere with your patient's ability to work eight hours per day, five days per week? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Please describe any difficulty your patient has with:

a. walking or standing: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

b. sitting for prolonged periods of time: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If your patient's legs should be elevated during prolonged sitting, what percentage of the time should they be elevated? \_\_\_\_\_

What symptoms cause a need to elevate the legs? \_\_\_\_\_  
\_\_\_\_\_

10. If your patient requires unscheduled breaks during the workday to rest because of symptoms, how many times per day would you expect this to happen? \_\_\_\_\_

11. How often is your patient likely to be "*off task*" because symptoms interfere with attention and concentration? \_\_\_\_\_

12. Please describe any other **limitations** (such as psychological limitations, limited vision, difficulty hearing, need to avoid temperature extremes, wetness, humidity, noise, dust, fumes, gases, or hazards, etc.) that would affect your patient's ability to work at a regular job on a sustained basis:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature*

*Printed/Typed Name:* \_\_\_\_\_

*Address:* \_\_\_\_\_

Please return completed form to:  
The Hardin Law Firm, PLC  
PO Box 1445, Cabot, AR 72023  
Phone: (501) 247-1830  
Fax: (501) 421-9237

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