

MEDICAL SOURCE STATEMENT - SHOULDER

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. Does your patient have major dysfunction of a shoulder? If yes, which one?

5. Does your patient have evidence of joint pain and stiffness in the affected shoulder?

6. Does your patient have any limitations of motion or other abnormal motion of the affected shoulder?

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

8. Please describe any difficulty your patient has with:
a. walking or standing: _____

b. sitting for prolonged periods of time: _____

c. reaching, handling, or fingering: _____

9. List any other **symptoms** that your patient exhibits, including pain, dizziness, fatigue, etc:

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 full-time job on a sustained basis:

Date

Signature

Printed/Typed Name: _____

Address: _____

Please return completed form to:

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