MEDICAL SOURCE STATEMENT FROM _____ TO NOW

_____ _____

NAME: SSN:

Diagnosis: _____

1. Must your patient elevate his lower extremity at waist-height or higher during the day? If so, how many hours?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 Hrs.

2. Does your patient need a walker or wheelchair during an 8-hour workday? If so, how many hours?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 Hrs.

3. Will your patient be off-task in an 8-hour workday due to leg pain? If so, how many hours?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 Hrs.

4. Will your patient miss work in an 8-hour workday due to leg pain? If so, how many hours?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 Hrs.

5. How long have you treated your patient? _____

6. What medical/clinical finding(s) support your conclusions in items 1-4?

_____ _____

Physician's Signature Date

_____

Printed Name Please