CANCER MEDICAL SOURCE STATEMENT

Patient: _____ Doctor: _____

SSN: XXX - XX - _____

1. Type or types of cancer diagnosed in patient:

Acute Leukemia	Adrenal Cancer	Anaplastic Adrenal Cancer	Astrocytoma – Brain Tumors Grade III & IV	Bladder Cancer
Bone Cancer	Breast Cancer	Chronic Myelogenous Leukemia (CML)	Ependymoblastoma (Child Brain Tumor)	Esophageal Cancer
Gallbladder Cancer	Glioblastoma Multiforme (Adult Brain Tumor)	Head and Neck Cancers	Inflammatory Breast Cancer (IBC)	Kidney Cancer
Large Intestine Cancer	Liver Cancer	Mantle Cell Lymphoma (MCL)	Mucosal Malignant Melanoma	Non-Small Cell Lung Cancer
Ovarian Cancer	Pancreatic Cancer	Peritoneal Mesothelioma	Pleural Mesothelioma	Small Cell Cancer (of the Large Intestine, Ovary, Prostate, or Uterus)
Small Cell Lung Cancer	Small Intestine Cancer	Stomach Cancer	Thyroid Cancer	Ureter Cancer

OTHER:

_____

_____

2. Has the patient had chemotherapy pre-surgery? _____YES _____NO

3. Has the patient had radiation treatment pre-surgery ? _____YES _____NO

4. Has the patient had surgery for the cancer ? _____YES _____NO

5. If there has been surgery, what type or types of surgery has been performed? _____

_____

6. What residual effects, if any, does the patient have from this surgery? _____

_____

_____

_____

7. Is more surgery contemplated? _____YES _____NO

8. If yes, what type of surgery would this be and when might this come up? _____

_____

_____

9. Has the patient had radiation treatment post-surgery ? _____YES _____NO

10. If radiation treatment has been given, pre or post surgery, when did this end or when do you expect it to end? _____

11. If radiation treatment has been given, pre or post surgery, how well has the patient tolerated treatment?

_____

_____

12. Has the patient had post surgery chemotherapy ? _____YES _____NO

13. If chemotherapy has been given, when did this end or when do you expect it to end? _____

14. If chemotherapy has been given, how well has the patient tolerated chemotherapy? _____

_____

_____

15. To what extent, if any, has the patient had significant emotional difficulty with the diagnosis of cancer or its treatment?

Psychiatric Limits	**Not Significant Impaired**	**Moderately Impaired**	**Markedly Impaired**	**Extremely Impaired**
a)The ability to understand, remember and carry out very short and simple instructions				
b)The ability to understand, remember and carry out detailed instructions				
c)The ability to maintain attention and concentration				
d)The ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances.				
e)The ability to work with others				
f)The ability to accept instructions and respond appropriately to criticism from supervisors.				
g)The ability to get along with coworkers				

16**. In my medical opinion this patient has the following limitations** (circle one):
In an average 8 hour working day 5 day working week, "occasionally" means less than 1/3 of the working day; "frequently" means between 1/3 to 2/3 of the working day.

a	**Hours patient can work consecutively per day**	None	1 hr	2 hrs	4 hrs	6 hrs	8 hrs
b	**Standing at one time**	None	15 min	30 min	60 min	2 hrs	4 hrs
c	**Sitting at one time**	None	15 min	30 min	60 min	2 hrs	4 hrs
d	**Lift/Carry occasionally**	None	5 lbs	10 lbs	20 lbs	50 lbs	More
e	**Lift/Carry frequently**	None	5 lbs	10 lbs	20 lbs	50 lbs	More
f	**From waist Bend or Twist**	Never	Occasionally	Frequently	Constantly		
g	**Stoop, Crouch, Crawl**	Never	Occasionally	Frequently	Constantly		
h	**Manipulation right hand**	Never	Occasionally	Frequently	Constantly		
i	**Manipulation left hand**	Never	Occasionally	Frequently	Constantly		
j	**Raise left arm over shoulder level**	Never	Occasionally	Frequently	Constantly		
k	**Raise right arm over shoulder level**	Never	Occasionally	Frequently	Constantly		

17. Does standing cause patient swelling in the lower extremities? _____Yes _____No

If yes, does patient need to sit and elevate legs for relief? _____Yes _____No

18. With prolonged sitting, should your patient's leg(s) be elevated? _____Yes _____No

If yes, how *high* should the leg(s) be elevated? _____

19. Are your patient's impairments likely to produce "good days" and "bad days"? ____Yes ____No
How often do you anticipate that your patient's impairments or treatment would cause absents from work?

___ Never ___ Less than 1day month ___ About 1 day month

___ About 2 days a month ___ About 3 days a month ___ More than 3days a month

20. Is your patient a malingerer? __ Yes __ No

21. Frequency and length of contact: _____

22. Prognosis: _____

Comments:
_____

_____

Date: _____

_____
Signature

_____
Print/Typed Name

Please return to:
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Rancho Cucamonga, CA 91730
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