MULTIPLE SCLEROSIS
MEDICAL SOURCE STATEMENT

To: _____

Re: _____ (Name of Patient)

_XXX - XX -_____ (Social Security No.)

Please answer the following questions concerning your patient's impairments. *Attach all relevant treatment notes, radiologist reports, laboratory and test results* **DATED FIRST VISIT TO PRESENT.**

1. Nature, frequency and length of contact: _____

2. Does your patient have multiple sclerosis? Yes No

   If yes, on what testing was this diagnosis based?

   _____

3. Prognosis:

   _____

4. Identify all of your patient's symptoms:

___	Fatigue	___	Pain
___	Balance problems	___	Difficulty remembering
___	Poor coordination	___	Depression
___	Weakness	___	Emotional lability
___	Paralysis	___	Difficulty solving problems
___	Unstable walking	___	Problems with judgment
___	Numbness, tingling or other	___	Double or blurred vision/partial or complete blindness
___	Sensory disturbance	___	Involuntary rapid eye movement_
___	Increased muscle tension (spasticity)	___	Shaking tremor
___	Bladder problems	___	Speech/communication
___	Bowel problems	___	Difficulties
___	Sensitivity to heat		

5. Is your patient a malingerer? Yes No

6. Does your patient have significant and persistent disorganization of motor function in two extremities resulting in sustained disturbance of gross and dexterous movement or gait and station?

Yes No

If yes, please describe the degree of interference with locomotion and/or interference with the use of fingers, hands and arms:

_____

_____

7. Does your patient have significant reproducible fatigue of motor function with substantial muscle weakness on repetitive activity, demonstrated on physical examination, resulting from neurological dysfunction in areas of the central nervous system known to be pathologically involved by the multiple sclerosis process?

Yes No

If yes, describe the degree of exercise and the severity of the resulting muscle weakness:

_____

_____

8. During the past two years, what are the approximate dates of exacerbations of multiple sclerosis?

_____

_____

9. Does your patient complain of a type of fatigue that is best described as lassitude rather than fatigue of motor function?

Yes No

If yes, is this kind of fatigue complaint typical of M.S. patients?

Yes No

10. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations?

Yes No

11. Are your patient's impairments (physical impairments plus any emotional impairments) *reasonably consistent* with the symptoms and functional limitations described in this evaluation?

Yes No

If no, please explain:

12. How often is your patient's experience of pain, fatigue or other symptoms severe enough to interfere with attention and concentration?

Never Seldom Often Frequently Constantly

13. To what degree is your patient limited in the ability to deal with work stress?

___ No limitation ___ Slight limitation ___ Moderate limitation

___ Marked limitation ___ Severe limitation

14. Have your patient's impairments lasted or can they be expected to last at least twelve months?

Yes No

15. What is the earliest date that the description of symptoms and *limitations* in this questionnaire applies?

16. As a result of your patient's impairments, estimate your patient's functional limitations if your patient were placed in a *competitive work situation:*

a. How many city blocks can your patient walk without rest? _____

b. Please circle the hours and/or minutes that your patient can *continuously* sit and stand *at one time*:

1. **Sit**:

0 5 10 15 20 30 45 (Minutes) 1 2 More than 2 (Hours)

2. **Stand**:

0 5 10 15 20 30 45 (Minutes) 1 2 More than 2 (Hours)

c. Please indicate how long your patient can sit and stand/walk *total in an 8 hour working day* (with normal breaks):

Sit	**Stand/walk**	
___	___	less than 2 hours
___	___	about 2 hours
___	___	about 4 hours
___	___	at least 6 hours

d. Does your patient need a job which permits shifting positions *at will* from sitting, standing or walking

Yes No

e. Will your patient sometimes need to take unscheduled breaks during an 8-hour working day?

Yes No

If yes, (1) how *often* do you think this will happen? _____

(2) how *long* (on average) will your patient have to rest before returning to work? _____

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

If yes, (1) how *high* should the leg(s) be elevated? _____

(2) if your patient had a sedentary job, *what percentage of time* during an 8-hour working day should the leg(s) be elevated?

_____%

g. While engaging in occasional standing/walking, must your patient use a cane or other assistive device?

Yes No

h. How many pounds can your patient lift and carry in a competitive work situation?

	Never	**Occasionally**	**Frequently**
less than 10 lbs.	___	___	___
10 lbs.	___	___	___
20 lbs.	___	___	___
50 lbs.	___	___	___

In an average 8 hour working day, "occasionally" means less than 1/3 of the working day; "frequently" means between 1/3 to 2/3 of the working day.

i. Does your patient have *significant limitations* in doing *repetitive* reaching, handling or fingering?

Yes No

j. Please state the percentage of time during an 8-hour working day that your patient can bend and twist at the waist.

Bend _____% Twist _____%

k. State the degree to which your patient should avoid the following:

ENVIRONMENTAL RESTRICTIONS:	NO RESTRICTION	AVOID CONCENTRATED EXPOSURE	AVOID EVEN MODERATE EXPOSURE	AVOID ALL EXPOSURE
Extreme cold				
Extreme heat				
High humidity				
Fumes, odors, dusts, gases				
Perfumes				
Cigarette smoke				
Soldering fluxes				
Solvents/cleaners				
Chemicals				
List other irritants or allergens:				

l. Are your patient's impairments likely to produce "good days" and "bad days"?

Yes No

If yes, please estimate, on the average, how often your patient is likely to be absent from work as a result of the impairments or treatment:

___ Never ___ About twice a month

___ Less than once a month ___ About three times a month

___ About once a month ___ More than three times a month

17. Please attach additional page to describe any other limitations that would affect your patient's ability to work at a regular job on a sustained basis.

18. Please indicate on what date the above restrictions became effective: _____

_____ _____

Date *Signature*

Printed/Typed Name: _____

Address: _____

_____

Please return to:
Driscoll Salazar Disability Group
8280 Aspen Ave. Ste 155
Rancho Cucamonga, CA 91730
P: 909-736-8559
F: 909-736-0405