Listing §1.04A – Spinal Nerve Root Compression

To: _____

Re: _____ (Name of Patient)

XXX - XX - _____ (Social Security No.)

Please comment on whether your patient has the following impairment:

> Disorders of the spine (e.g., herniated nucleus pulposus, spinal arachnoiditis, spinal stenosis, osteoarthritis, degenerative disc disease, facet arthritis, vertebral fracture), resulting in compromise of a nerve root (including the caudal equina) or the spinal cord. With:
>
> A. Evidence of nerve root compression characterized by neuro-anatomic distribution of pain, limitation of motion of the spine, motor loss (atrophy with associated muscle weakness or muscle weakness) accompanied by sensory or reflex loss and, if there is involvement of the lower back, positive straight-leg raising test (sitting and supine).

1. Does your patient have a disorder of the spine? __Yes __ No

   If yes, please identify the disorder: _____

2. Does your patient have evidence of nerve root compression? __Yes __ No

3. Does your patient have neuro-anatomic distribution of pain? __Yes __ No

   If yes, please describe: _____

   _____

4. Does your patient have any limitation of motion of the spine? __Yes __ No
   If yes, indicate range of motion with the following movements:

   Flexion ____° Lateral bending - right ____°
   Extension ____° Lateral bending - left ____°

   Other: _____

5. Does your patient have any muscle weakness? __Yes __ No

   If yes, please identify the affected muscles and describe using the grading system 0 to 5:

   _____

   Identify any positive signs of motor loss:

   __ Inability to walk on heels
   __ Inability to walk on toes
   __ Inability to squat
   __ Inability to arise from squatting position
   __ Atrophy: Indicate circumferential measurements of both thighs and lower legs or upper and lower arms as appropriate:

   _____

6. Does your patient have sensory *or* reflex loss? __ Yes __ No

If yes, please describe: _____

_____

7. Is there involvement of the lower back? __ Yes __ No

If yes, does your patient have a positive straight-leg raising test *both* sitting and supine?
__ Yes __ No

Please describe: _____

_____

8. If the clinical findings do not match ***all*** of the findings required above, are your patient's combined impairments medically ***equivalent*** to the severity of conditions in the above listed impairment?
__ Yes __ No

If yes, please explain in detail how your patient's impairments are equivalent to the impairment listed above, with reference to ***specific supporting clinical findings.***

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

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