PHYSICAL MEDICAL SOURCE STATEMENT – SHORT FORM

Patient Name:_____

Provider Name:_____

Diagnoses:_____

First Date You Saw Patient: _____
Frequency of Treatment_____

OPINION OF PATIENT'S CAPACITY TO PERFORM WORK ACTIVITIES

Please provide your opinion as to your patient's ability to perform work activities in an 8-hour workday:

1. HEAVIEST WEIGHT THEY COULD LIFT AT ONE TIME IN POUNDS (circle answer):

   0 10 20 25 50 100

2. HOW LONG CAN THEY STAND OR WALK TOTAL IN AN 8-HOUR WORKDAY:

   0HRS <2HRS 2-4HRS 4-6HRS 6-8HRS

3. HOW LONG CAN THEY SIT TOTAL IN AN 8-HOUR WORKDAY:

   0HRS <2HRS 2-4HRS 4-6HRS 6-8HRS

4. IF THEIR SYMPTOMS WOULD CAUSE THEM TO BE OFF-TASK/DISTRACTED AT WORK, HOW LONG WOULD THEY BE OFF-TASK TOTAL IN AN 8-HOUR WORKDAY:

   0MIN 15MIN 30MIN 60MIN 60MIN+

5. IF THEIR CONDITION(S) WOULD CAUSE THEM TO MISS WORK OR BE LATE TO WORK, HOW MANY DAYS WOULD THIS HAPPEN PER MONTH:

   0DAYS 1DAY 2DAYS 3DAYS 3+DAYS

6. WHAT IS THE EARLIEST DATE THAT THE ABOVE LIMITATIONS BEGAN: _____

Briefly, what medical conditions/symptoms do they have that support your answers above?

_____
_____
_____
_____

_____ _____

Signature Date