POST CANCER TREATMENT MEDICAL SOURCE STATEMENT

From: _____

Re: _____ (Name of Patient)

_____ (Social Security No.)

Please answer the following questions concerning your patient's impairments. *Attach relevant treatment notes, radiologist reports, laboratory and test results as appropriate.*

1. Frequency and length of contact:_____

2. If your patient has been diagnosed with and treated for cancer,

   a. Please identify the type of cancer: _____

   b. Cancer status: ☐ Remission ☐ Other: _____

   c. Does your patient have ***chronic fatigue*** as a result of cancer or treatment (including radiation and/or chemotherapy)? ☐ Yes ☐ No

   d. Please identify your patient's other impairments that could cause or exacerbate your patient's chronic fatigue:

      ☐ HIV-AIDS ☐ Rheumatoid arthritis ☐ Depression
      ☐ Fibromyalgia ☐ Lyme disease ☐ Side effects of medications
      ☐ Chronic fatigue syndrome (CFS)
      ☐ Other _____

3. Other Diagnoses:_____

4. Prognosis: _____

5. Please list ***signs and symptoms*** (other than fatigue) your patient has as a result of cancer or treatment?

   ☐ Muscle pain ☐ Chronic headaches ☐ Disturbed sleep
   ☐ Depression ☐ Anxiety ☐ Impaired memory
   ☐ Muscle weakness ☐ Impaired attention/concentration
   ☐ Lower extremity edema
   ☐ Other: _____

6. Identify any side effects of current medication that may have implications for working:

   _____

7. Have your patient's impairments lasted or can they be expected to last at least twelve months? ☐ Yes ☐ No

8. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations? ☐ Yes ☐ No

9. Identify any psychological conditions affecting your patient's physical condition:

☐ Depression	☐ Anxiety
☐ Somatoform disorder	☐ Personality disorder
☐ Psychological factors affecting physical condition	☐ Other: _____

10. 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 ***at one time*** before stopping? _____

b. Please circle the hours and/or minutes that your patient can sit ***at one time***, e.g., before needing to get up, etc.

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

c. Please circle the hours and/or minutes that your patient can stand ***at one time***, e.g., before needing to sit down, walk around, etc.

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

d. 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

e. Is your patient capable of working an 8-hour working day, 40 hours per week?
☐ Yes ☐ No

If no, approximately ***how many hours per week*** can your patient work?
10 15 20 25 30
Hours

f. Does your patient need a job that permits shifting positions at will from sitting, standing or walking? ☐ Yes ☐ No

g. If your patient's symptoms would likely cause the need to take ***unscheduled breaks*** to rest during a workday,

1) ***How many times*** during an average workday do you expect this to happen?

0 1 2 3 4 5 6 7 8 9 10, More than 10

2) ***How long*** (on average) will your patient have to rest before returning to work? 2 3 5 10 20 30 45 Minutes 1 2 More than 2 Hours

3) What symptoms cause a need for breaks?

☐ Pain/arthralgia ☐ Fatigue ☐ Nausea
☐ Medication side effects ☐ Other:_____

h. 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? _____ %

For this and other questions on this form, "rarely" means 1% to 5% of an 8-hour working day; "occasionally" means 6% to 33% of an 8-hour working day; "frequently" means 34% to 66% of an 8-hour working day.

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

	Never	**Rarely**	**Occasionally**	**Frequently**
Less than 10 lbs.		☐	☐	☐
10 lbs.	☐	☐	☐	☐
20 lbs.	☐	☐	☐	☐
50 lbs.	☐	☐	☐	☐

j. How often can your patient perform the following activities?

	Never	**Rarely**	**Occasionally**	**Frequently**
Twist	☐	☐	☐	☐
Stoop (bend)	☐	☐	☐	☐
Crouch/ squat	☐	☐	☐	☐
Climb ladders	☐	☐	☐	☐
Climb stairs	☐	☐	☐	☐

k. If your patient has significant limitations with reaching, handling or fingering, please indicate the percentage of time during an 8-hour working day that your patient can use hands/fingers/arms for the following activities:

	HANDS: Grasp, Turn Twist Objects	**FINGERS: Fine Manipulations**	**ARMS: Reaching In Front of Body**	**ARMS: Reaching Overhead**
Right:	**%**	**%**	**%**	**%**
Left:	**%**	**%**	**%**	**%**

l. How much is your patient likely to be ***"off task"***? That is, what percentage of a typical workday would your patient's symptoms likely be severe enough to interfere with ***attention and concentration*** needed to perform even simple work tasks?

☐ 0% ☐ 5% ☐ 10% ☐ 15% ☐ 20% ☐ 25% or more

m. To what degree can your patient tolerate work stress?

☐ Incapable of even "low stress" work
☐ Capable of low stress work
☐ Capable of moderate stress - normal work
☐ Capable of high stress work

Please explain the reasons for your conclusion: _____

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

☐ Yes ☐ No

If yes, assuming your patient was trying to work full time, please estimate, on the average, how many days per month your patient is likely to be absent from work as a result of the impairments or treatment:

☐ Never
☐ About one day per month
☐ About two days per month
☐ About three days per month
☐ About four days per month
☐ More than four days per month

12. Are your patient's impairments (physical impairments plus any emotional impairments) as demonstrated by signs, clinical findings and laboratory or test results ***reasonably consistent*** with the symptoms and functional limitations described above in this evaluation?

☐ Yes ☐ No

If no, please explain: _____

13. Please describe any other limitations (such as psychological limitations, limited vision, difficulty hearing, need to avoid temperature extremes, wetness, humidity, noise, dust, fumes, gases or hazards, etc.) that would affect your patient's ability to work at a regular job on a sustained basis:

_____

_____

_____

_____ _____

Date *Signature*

Printed/Typed Name: _____

Address: _____

_____

_____