LUPUS (SLE) 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. Does your patient fulfill the diagnostic criteria for systemic lupus erythematosus (SLE) identified by the American College of Rheumatology (namely, ***exhibit at any time at least four of the first eleven signs or symptoms listed in question #4 below)***?

   ☐ Yes ☐ No

3. Other diagnoses: _____

   _____

4. Identify any clinical findings, laboratory and test results, symptoms and positive objective signs of your patient's impairment (or adverse effects of treatments):

a.	☐	Malar rash (over the cheeks)	c.	☐	Photosensitivity
b.	☐	Discoid rash	d.	☐	Oral ulcers

e.	☐	Non-erosive arthritis involving pain in two or more peripheral joints. ***Note if affected joints also exhibit:*** ☐ tenderness ☐ swelling ☐ effusion	Identify affected joints: _____ _____ _____

f.	☐	Cardiopulmonary involvement shown by pleuritis or pericarditis
g.	☐	Renal involvement shown by a) persistent proteinuria shown by: ☐ greater than 0.5 gm/day ***or*** ☐ 3+ on test sticks ***or*** b) ☐cellular casts.
h.	☐	Central nervous system involvement shown by seizures and/or psychosis (in absence of drugs or metabolic disturbances known to cause such effects)
i.	☐	Hemolytic anemia ***or*** leukopenia (white blood count below 4,000/mm^3) ***or*** lymphopenia (below 1,500 lymphocytes/mm^3) ***or*** thrombocytopenia (below 100,000 platelets/mm^3)
j.	☐	Anti-DNA ***or*** anti-Sm anti-body ***or*** positive finding of antiphospholipid

		antibodies based on 1) abnormal serum level of IgG or IgM anticardiolipin antibodies, 2) a positive test result for lupus anticoagulant using a standard method or 3) a false-positive serologic test for syphilis known to be positive for at least six months and confirmed by Treponema pallidum immobilization or fluorescent treponemal antibody absorption test.
k.	☐	Positive test for ANA at any point in time (in absence of drugs known to cause abnormality)

l. Constitutional Symptoms

	☐	Severe fatigue	☐	Fever
	☐	Involuntary weight loss	☐	Malaise

m. List any other signs or symptoms:_____

_____

_____

5. Identify Major Organ or Body System Involvement ***at least to a moderate degree***

☐		**Respiratory**	☐		**Renal** - Glomerulonephritis
	☐	Pleuritis	☐		**Neurologic** - Seizures
	☐	Pneumonitis	☐		**Mental**
☐		**Cardiovascular**		☐	Anxiety
	☐	Endocarditis		☐	Fluctuating cognition – lupus fog
	☐	Myocarditis		☐	Mood disorders
	☐	Pericarditis		☐	Organic brain syndrome
	☐	Vasculitis		☐	Psychosis
☐		**Hematologic**	☐		**Other immune system disorder**
	☐	Anemia		☐	Inflammatory arthritis
	☐	Leukopenia		☐	Sjögren's syndrome
	☐	Thrombocytopenia	☐		**Skin**

6. Functional Limitations

Limitation of activities of daily living	None or Mild ☐	Moderate ☐	Marked ☐
Limitation in maintaining social functioning	None or Mild ☐	Moderate ☐	Marked ☐
Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence or pace	None or Mild ☐	Moderate ☐	Marked ☐

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

8. Identify prescribed medications and treatments and the side effects of any medication (particularly of steroids, if applicable) that may have implications for working, e.g., dizziness, drowsiness, stomach upset, cataracts, liver damage, etc.:

9. Prognosis: _____

10. Have your patient's impairments lasted or can they be expected to last at least 12 months?
☐ Yes ☐ No

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

f. Will your patient sometimes need to take unscheduled breaks during a 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? _____

3) on such a break, will your patient need to ☐ lie down or ☐ sit quietly?

g. While engaging in occasional standing/walking, must your patient use a cane or other assistive device? ☐ Yes ☐ No

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.

h. 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.	☐	☐	☐	☐

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

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

j. 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:	**%**	**%**	**%**	**%**

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

ENVIRONMENTAL RESTRICTIONS	**NO RESTRICTIONS**	**AVOID CONCENTRATED EXPOSURE**	**AVOID EVEN MODERATE EXPOSURE**	**AVOID ALL EXPOSURE**
Extreme cold	☐	☐	☐	☐
Extreme heat	☐	☐	☐	☐
High humidity	☐	☐	☐	☐
Wetness	☐	☐	☐	☐
Cigarette smoke	☐	☐	☐	☐
Perfumes	☐	☐	☐	☐
Soldering fluxes	☐	☐	☐	☐
Solvents/cleaners	☐	☐	☐	☐
Fumes, odors, gases	☐	☐	☐	☐
Dust	☐	☐	☐	☐
Chemicals	☐	☐	☐	☐
List other irritants:	☐	☐	☐	☐

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, etc.) that would affect your patient's ability to work at a regular job on a sustained basis:

_____

_____

_____

_____ _____

Date *Signature*

Printed/Typed Name: _____

Address: _____

_____