MULTIPLE SCLEROSIS 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 have multiple sclerosis? ☐ Yes ☐ No

   If yes, how was this diagnosis made? _____

3. Prognosis: _____

4. Identify all of your patient's ***symptoms and signs***:

☐ Chronic fatigue	☐ Sensitivity to heat	☐ Loss of manual dexterity
☐ Balance problems	☐ Unstable walking	☐ Poor coordination
☐ Paresthesias	☐ Pain	☐ Numbness
☐ Paralysis	☐ Muscle spasticity	☐ Muscle atrophy
☐ Weakness	☐ Muscle fatigue of limb	☐ Static tremor
☐ Intention tremor	☐ Cerebellar ataxia	☐ Speech difficulties
☐ Increased deep reflexes	☐ Vertigo	☐ Dimness of vision
☐ Pain in one eye	☐ Nystagmus	☐ Partial blindness
☐ Blurred vision	☐ Double vision	☐ Other vision disturbance
☐ Bowel problems	☐ Bladder problems	☐ Problems with judgment
☐ Depression	☐ Emotional lability	☐ Personality change
☐ Difficulty remembering	☐ Confusion	☐ Difficulty solving problems

   Other symptoms, signs and clinical findings: _____

   _____

5. Have your patient's impairments lasted or can they be expected to last at least twelve months? ☐ 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. a. During the past year what are the approximate dates of exacerbations of M.S.?

   _____

   b. Of the exacerbations listed above, circle the ones that would prevent ***any work for more than one month.***

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. 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 or severe pain? _____

    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) what symptoms cause a need for breaks?

☐ Muscle weakness ☐ Pain/ paresthesias, numbness
☐ Chronic fatigue ☐ Adverse effects of medication
☐ Other: _____

g. 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? _____ %

3) what symptoms cause a need to elevate the leg(s)? _____

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

If yes, what symptoms cause a need to use a cane?

☐ Muscle weakness ☐ Spasticity ☐ Chronic fatigue
☐ Incoordination ☐ Imbalance ☐ List others in margin

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	☐	☐	☐	☐

k. If your patient has significant limitations with reaching, handling or fingering:

What symptoms cause limitations of use of the upper extremities?

☐ Pain/ paresthesias ☐ Incoordination ☐ Sensory loss/ numbness
☐ Muscle weakness ☐ Spasticity ☐ Fatigue
☐ Tremor ☐ Other: _____

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

n. 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: _____

o. 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

11. 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: _____

12. Please describe any other limitations (such as psychological limitations, limited vision, difficulty hearing, difficulty speaking, need to avoid temperature extremes, wetness,

humidity, noises, dust, fumes, gases or hazards, etc.) that would affect your patient's ability to work at a regular job on a sustained basis.

_____

_____

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

_____ _____

Date *Signature*

Printed/Typed Name: _____

Address: _____

_____

_____