

Ohio DDD Internal Medicine Consultative Examination Guidelines

Part II: Internal Medicine Consultative Examination Guidelines

General Examination/Report Requirements

Introduction and Required Components

Make sure the report - through its thoroughness and the presentation and interpretation of evidence - demonstrates that a genuine effort has been made to identify all diagnoses and probable diagnoses, as well as formulate a carefully thought-out assessment of current functional status ("Medical Source Statement").

Make sure that the report documents the positive elements of the medical history and physical examination, as well as the negative elements. This is crucial because DDD cannot accept that an element of the history or physical examination was negative or normal unless it was explicitly stated to be negative or normal.

Make sure that all of the following requirements are met and documented in the report narrative using appropriate headings:

- A. Identify the Claimant
 - B. List All Chief Complaints
 - C. Elaborate on Each Complaint in the History of Present Illness
 - D. Document All Elements of Medical History
 - E. List All Medications
 - F. Document the Family History
 - G. Document the Social History
 - H. List Results of the Review of Systems
 - I. Measure Vital Signs
 - J. Measure Visual Acutities
 - K. Describe Claimant's General Appearance and Presentation
 - L. Examine the Head, Eyes, Ears and Throat
 - M. Examine the Neck
 - N. Examine the Lungs
 - O. Examine the Heart
- Note: Do Not Perform Breast Exams**
- P. Examine the Abdomen
 - Q. Observe and Examine the Back and Spine
- Note: Do Not Perform Rectal or Pelvic Exams**
- R. Examine Extremities and Measure Ranges of Motion
 - S. Perform a Neurological Examination
 - T. Examine the Skin
 - U. Review Medical Records from DDD
 - V. Review Results of X-Rays or Other Tests Performed in Your Office
 - W. List All of Your Diagnostic Impressions

- X. Provide a Functional Statement ("Medical Source Statement")
- Y. State Whether the Claimant Can Safely Undergo an Exercise Test
- Z. Enter the Manual Muscle Test Results in the Neuromuscular Data Sheet
- AA. Enter the Range of Motion Test Results in the Neuromuscular Data Sheet
- AB. 1151 Form
- AC. Proofread
- AD. Signature

What If a Report is Inadequate?

If a report contains errors, DDD will need you to prepare an addendum that contains corrections or clarifying information. *Note: you are not paid for drafting addenda.*

If a report is missing important historical information or elements of the physical examination, DDD will need you to prepare an addendum and, in some cases, will require you to reexamine the claimant in your office at your own expense.

DDD understands that in some cases a claimant may be uncooperative. Document this in your report.

Thoroughness and Time Spent During the History and Physical

DDD does not want you to rush through these important examinations, which are distinct from your regular examinations in the course of medical practice. Sometimes a consultative examination is the only medical evidence DDD will receive, making it vital to the determination process.

You need not create a therapeutic relationship during a consultative examination, but do allow enough time so that some degree of rapport can be developed between examiner and examinee. Allow ample time for the claimant to state all of his or her complaints and symptoms and to answer all of the questions with minimal interruptions from the examiner. This may take about an hour, but SSA requires that the history and physical (not including the writing and dictating of the report) must take 30 minutes or more.

Avoid excessively brief examinations. Important elements of the history or physical could be omitted during a cursory history and physical, which could result in the consultant having to complete a request for a clarifying addendum or even

reexamine the claimant at the consultant's own expense. SSA requires that all claimant complaints be investigated, and one of the most common complaints is that an examination was too brief.

Who Is Permitted to Perform Various Parts of the Examination?

DDD realizes that a physician is not needed to weigh, measure height, take blood pressure and pulse, or even measure visual acuity; however, SSA has published criteria that specify who can and who cannot do various aspects of the history, physical examination and ancillary testing.

The Green Book states: "The medical source chosen may use support staff to help perform the consultative examination. Any such support staff (e.g., X-ray technician, nurse, etc.) must meet appropriate licensing or certification requirements of the State."

DDD has no problem with some elements of the examination or testing being performed by appropriate support staff, which would include licensed and certified physician extenders like physician assistants and nurse practitioners. Similarly, a licensed and certified physical therapist or occupational therapist could measure ranges of motion and a licensed and certified respiratory therapist could conduct spirometry or other pulmonary function testing. Except for these substitutions, DDD expects that the physician personally perform all of the following:

- Take the history
- Examine the claimant
- Conduct ancillary testing

Some physicians use patient-completed questionnaires. If you use one or more of these forms, you must still go through the claimant's chief complaints, history of present illness, past medical history, family history, social history and review of systems using spoken questions that elicit spoken responses (unless the claimant cannot speak). DDD cannot assume that all claimants can read or comprehend the printed questions on a questionnaire. The entire, or vast majority of the consultative examination, must involve face-to-face verbal interaction.

Professionalism and Complaints

DDD follows a formal procedure when a complaint is received. Common complaints in the past, in addition to allegations of an excessively brief examination encounter, have included that the consultant:

- Was rude
- Asked questions too quickly
- Did not give the claimant enough time to answer the questions
- Was rough when testing range of motion
- Had a poor bedside manner
- Told the claimant he/she was not disabled
- Told the claimant to go get a job

If any complaint is received, DDD will write you, request a written response to the claimant's allegations and evaluate your response.

If a consultant receives multiple complaints, DDD will investigate and may cease to do business with that consultant.

You must be sincere and professional in all of your encounters with claimants.

Routine Review of Consultative Examination Quality

A statistical sample of reports is reviewed weekly by DDD's Chief Medical Consultant. When a report is found to be unsatisfactory, a letter is sent to the consultant, who must then submit a clarifying addendum. DDD monitors reports that deviate from SSA and DDD standards; however, most consultants regularly meet or exceed examination/report standards. When DDD does find poor quality reports, with no improvement in response to constructive criticism, the agency may cease to do business with a consultant.

Definite and Probable Diagnoses: Dealing with Uncertainty

The primary reason DDD needs your services through a consultative examination is that the agency has received little or no medical evidence from a claimant's treating sources. This is usually because the treating sources have not responded to medical records requests or the claimant does not have a treating source. As a result, when you see a DDD claimant, you may not have other medical data that would assist you in definitively diagnosing any impairments or conditions that he or she may have.

Because of the lack of medical testing and other data, you may not have enough information to make one or more definitive diagnoses on the basis of a one-time history and physical examination. It is acceptable to mention probable diagnoses. For example, in a claimant with a long history of knee pain who, upon examination, has an antalgic gait plus a swollen, tender knee with decreased range of motion, it is recommended that you list "probable osteoarthritis of the knee" in your list of diagnoses even though you do not have X-ray or MRI confirmation.

Voucher Information

Read all of the voucher information so that you are aware of and can complete all that is requested. On some occasions, there are special instructions about specific elements of the history or physical upon which DDD would like you to focus and comment. Common special instructions and questions include:

- Can the claimant hear conversational speech?
- Does the claimant have brawny edema and if so, how far up the leg does it extend?
- Has the claimant's foot ulcer healed?

Conducting Tests that Have Not Been Ordered

In the past, some consultants - on their own - have decided that an unordered test would be helpful and have gone on to perform the test. **This must not be done.** Payment will not be rendered for testing that is not pre-approved and ordered on the voucher.

How to Add a Test

If you think it would be beneficial to add a test, such as a weight-bearing joint X-ray or spirometry, call DDD to discuss the suggestion. Sometimes, the agency will approve the added test. You will be paid for the test **only** if you follow proper procedures and get approval in advance.

Non-English-Speaking Claimants

For non-English speaking claimants, the history must be obtained from family members present during the exam or from an interpreter contracted by the DDD. Report communication difficulties whether due to:

- Language barrier
- Difficulty hearing
- Difficulty speaking
- Difficulty seeing
- Cognitive impairment
- Mental illness
- Other

Specific Examination/Report Requirements

Identify the Claimant

Compare the claimant's countenance with a valid photo identification card.

List All Chief Complaints

- Give claimant ample time to name complaints.
- Instead of asking, "Why can't you work?" be general and ask, "What sorts of physical problems and symptoms do you have?"
- Report from whom you obtained the medical history.
- Record whether you believe the claimant or other informant was reliable in presenting the history.

Elaborate on Each Complaint in the History of Present Illness

- Elaborate fully on each symptom and specific illness stated as a chief complaint.
- Record when each major symptom and each specific illness began.
- Explain how each specific illness was diagnosed.
- Describe the severity of each symptom and specific illness at onset and how the severity has changed or progressed.
- Document the treatments, surgeries or procedures that have been done and how successful they have been.
- Report illnesses with episodic exacerbations (asthma, chronic obstructive pulmonary disease (COPD), heart failure, angina, seizures, hyperglycemia or ketoacidosis, recurrent pancreatitis, recurrent abdominal pain of other causes) in a special way:
 - » List the dates of all exacerbations.
 - » Report whether the claimant was treated in the emergency department or admitted to the hospital.
 - » Describe the treatments.
 - » State what precipitated the exacerbations (if known).

- Report symptoms or specific illnesses associated with pain in a special way:
 - » Describe where the pain is located (describe all areas if multiple sites).
 - » State whether there is a known (or probable) underlying disease or disorder to which pain can be attributed.
 - » Describe the character of the pain.
 - » Record when the pain first occurred and how it has changed or progressed.
 - » List what makes the pain worse.
 - » List what makes the pain better.
 - » Describe the treatments, surgeries or procedures that have been done and how successful they have been.
- For examples of specific questions for four common chief complaints (chest pain/discomfort, shortness of breath, back pain and knee pain), see *"Examples of Key Questions for Four Common Chief Complaints" (Part II - Appendix A)*.

Document All Elements of Medical History

- List significant traumas
- List surgeries and significant procedures
- List recent transfusions
- List hospitalizations
- List all medical diagnoses

List All Medications

Document Family History

If present, list family histories of:

- Coronary artery disease
- Stroke
- Peripheral arterial disease
- Seizures
- Neurodegenerative diseases
- Asthma
- Genetic diseases

Document Social History

List whether the following have been used and the extent of use (i.e., pack years, etc.):

- Tobacco (smoking)
- Tobacco (smokeless)
- Alcohol
- Illicit drugs

List Results of the Review of Systems

- Record the positive results.
- Record the negative results. DDD cannot assume a symptom was absent if not explicitly stated.

Measure Vital Signs

Report each of the following:

- Measured height without shoes
- Measured weight without shoes
- Sitting blood pressure
- Sitting pulse
- Sitting respiratory rate
- Oral temperature if you believe the claimant is febrile
- If severe kyphoscoliosis is present, report measured arm span (finger tips to finger tips)

It is helpful, but not required, that you calculate and record body mass index (BMI). (Note: morbid obesity (BMI 40+) is a medically-determinable impairment per SSA.)

Measure Visual Acuities

- Measure in all claimants.
- Measure each eye separately with the claimant wearing his or her glasses/contacts if applicable. Note if a claimant wears glasses/contacts but did not bring them to the exam.
- Describe acuities of worse than 20/200 by the standard qualitative measures:
 - » No light perception
 - » Light perception
 - » Hand motion
 - » Counts fingers (at specified distances)
- Record any diagnosed eye diseases under "History of Present Illnesses" if visual impairment is a chief complaint, or under "Past Medical History," if visual impairment is not a chief complaint.

Describe Claimant's General Appearance and Presentation

- Describe the salient features of your first impression of the claimant in detail.
- Especially important are observations of:
 - » Mobility
 - » Dexterity
 - » Acute illness
 - » Chronic illness
 - » Morbid obesity
 - » Malnutrition
 - » Apparent psychosis or dementia

- Assess the claimant's ability to hear and understand conversational speech.
- Assess the claimant's ability to produce clear, sustained speech.

Examine the Head, Eyes, Ears and Throat

- Check for the red reflex and note the presence (if any) of cataracts.
- Note conjunctival pallor, if present.
- Note the color of the sclera.
- Assess pupil reactivity.
- Test extraocular muscle function and note strabismus, if present.
- Assess ear canal patency and tympanic membrane integrity and appearance.

Examine the Neck

Check for:

- Lymphadenopathy
- Jugular venous distention at about 45 degrees
- Carotid bruits

Examine the Lungs

Record any of these findings, if present:

- Diminished intensity (loudness) of breath sounds
- Pursed-lip breathing
- Tripod sitting
- "Barrel chest"
- Prolonged expiration phase of respirations
- Wheezes
- Crackles
- Labored breathing
- Cyanosis

Examine the Heart

Record any of these findings, if present:

- Lateral displacement of the apical impulse on palpation
- Diffuse size of the apical impulse on palpation
- S3
- S4
- Murmurs, especially those of aortic or mitral stenosis or regurgitation

Record volume/intensity of peripheral pulses under "Examine the Extremities."

Examine the Abdomen

Record any of these findings, if present:

- Ascites or "probable" ascites
- Palpable spleen
- Palpable masses
- Incisional hernias or open wounds
- Ventral hernias
- Inguinal hernias
- Palpable liver edge
- Abdominal wall collateral veins

If the liver is palpable, percuss the upper and lower margins of the liver and record the span in centimeters.

Examine the Back and Spine

- Record any of the following findings, if present:

- » Kyphosis
- » Scoliosis
- » Paraspinal muscle spasm
- » Paraspinal tenderness
- » Sacroiliac joint tenderness
- » Vertebral tenderness
- » Listing of the lower back that makes one hip appear higher than the other
- » Surgical scars

- If myofascial pain or fibromyalgia is alleged, palpate the tender point locations as specified by the American College of Rheumatology
- Measure spinal ranges of motion and record the measurement on the *Range of Motion section of the Neuromuscular Data Sheet (Part II - Appendix B)*.
- Perform the straight leg raising test in the sitting and supine positions, recording whether there is:
 - » No pain
 - » Pain in the back
 - » Pain that radiated down the leg to the foot
 - » Pain in the back plus pain that radiated down the leg to the foot

Examine the Extremities and Measure Ranges of Motion

Focus the extremity exam on eight major areas:

1. Measure the active and passive ranges of motion of all major joints as listed on the *Range of Motion section of the Neuromuscular Data Sheet (Part II - Appendix B)*.
 - » Preferably use a goniometer for these measurements
 - » Record these measurements on the *Range of Motion section of the Neuromuscular Data Sheet (Part II - Appendix B)*
 2. Observe and palpate painful joints, joints with decreased range of motion and joints that appear grossly abnormal.
 - » Record any of the following joint findings, if present:
 - *Bony enlargement*
 - *Swelling or effusion*
 - *Synovial thickening*
 - *Warmth*
 - *Erythema*
 - *Tenderness*
 - *Pain with range of motion maneuvers*
 - *Deformities, such as ulnar deviation, or varus or valgus deformities of the knee*
 - *Contractures*
 - *Ligamentous laxity*
 - *Crepitus*
 3. Observe gait in detail.
 - » A detailed gait description is needed if the claimant:
 - *Has a visible limp or other abnormality of gait*
 - *Alleges trouble walking or maintaining balance*
 - *Has had a stroke or has another neuromuscular condition*
 - *Has pain, decreased range of motion or an abnormality on examination of the foot/ankle, knee, hip or spine*
 - » A detailed gait description includes all of the following:
 - *Describe exactly what you observe when the claimant walks or attempts to walk (see Appendix C for select abnormalities of gait).*
 - *If the claimant uses a hand-held assistive device, if safe to do so, observe the claimant attempting to walk without the assistive device.*
 4. Observe hand function in detail.
 - » Using the *Range of Motion section of Neuromuscular Data Sheet (Part II - Appendix B)*, record whether the claimant can:
 - *Open a door*
 - *Open a jar*
 - *Pick up keys*
 - *Pick up a coin*
 - *Write*
 - *Button*
 - *Unbutton*
 - *Zip*
 - *Unzip*
 - » Using the *Manual Muscle Testing section of Neuromuscular Data Sheet (Part II - Appendix B)*, describe claimant's ability to:
 - *Grasp (grabbing, as in a hand shake)*
 - *Manipulate (handle)*
 - *Pinch (between the thumb and index finger)*
 - *Finely manipulate (rely on finger functioning as in typing)*
 5. Observe limb bulk and symmetry for atrophy or differences in the sizes of the opposite extremities.
 - » Using the *Range of Motion section of Neuromuscular Data Sheet (Part II - Appendix B)*, record measurements of the circumference of the forearms, arms, thighs and legs if there is suspicion of atrophy or asymmetry due to swelling/edema.
- *If the claimant uses a hand-held assistive device, decide whether it is necessary (obligatory) to allow ambulation in each of these circumstances:*
 - *Short distances on level surfaces*
 - *Long distances on level surfaces*
 - *Short distances on uneven surfaces*
 - *Long distances on uneven surfaces*
 - *Is the claimant a fall risk?*
 - *Attempt to estimate how many total hours (per eight-hour workday) the claimant can be in the upright position ("on his or her feet") either standing or walking (combined).*

6. Observe the feet and ankles without socks and shoes.
 - » Record any of these findings, if present:
 - *Edema (graded trace through 4+)*
 - *Lymphedema (usually the foot is swollen in addition to the ankle)*
 - *Brawny edema (if present, remark how high up each leg it extends)*
 - *Foot or ankle or leg ulcers (if present, note location, depth, diameter, and appearance)*
7. Palpate peripheral pulses and look for signs of arterial insufficiency.
 - » Grade pulses “not palpable” through 4+
 - » Remark if there is:
 - *Dependent rubor*
 - *Blanching on elevation of the leg*
 - *Skin atrophy*
 - *Loss of hair growth*
8. In amputations, observe the status of the stump.
 - » If a claimant has a prosthesis, describe ambulation with it in place.
 - » If a claimant does not have a prosthesis, observe and describe ambulation (if this can be safely done).
4. Perform funduscopic examination looking particularly for optic atrophy and papilledema (*see Examine the Head, Eyes, Ears and Throat*).
 - » Attempt to elicit Babinski’s sign
 - » Conduct motor strength proxy tests including:
 - *Ability to rise from the seated position without using hands*
 - *Ability to mount the examination table*
 - *Ability to dismount the examination table*
 - *Toe-walking*
 - *Heel-walking*
 - *Pronator drift*
5. Observe gait in detail (*see Examine the Extremities and Ranges of Motion*).
 - » Record any of these findings, if present:
 - *Clonus*
 - *Increased muscle tone*
 - *Muscle hypertrophy*
 - *Decreased muscle tone*
 - *Spasticity*
 - *Flaccidity*
 - *“Cog-wheeling” rigidity*
 - *“Lead-pipe” rigidity*
 - *Lack of arm swing with walking*
 - *Slowness of movement (bradykinesia)*
6. Describe hand function in detail (*see Examine the Extremities and Ranges of Motion*).
 - » Record any of these findings, if present:
 - *Clonus*
 - *Increased muscle tone*
 - *Muscle hypertrophy*
 - *Decreased muscle tone*
 - *Spasticity*
 - *Flaccidity*
 - *“Cog-wheeling” rigidity*
 - *“Lead-pipe” rigidity*
 - *Lack of arm swing with walking*
 - *Slowness of movement (bradykinesia)*
7. Examine motor strength in all major muscle groups graded as 0 through 5, where 5 is normal. Record this on the *Manual Muscle Testing section of the Neuromuscular Data Sheet (Part II - Appendix B)*, which in addition, describes the five muscle strength grades.
 - » Record any of these findings, if present:
 - *Clonus*
 - *Increased muscle tone*
 - *Muscle hypertrophy*
 - *Decreased muscle tone*
 - *Spasticity*
 - *Flaccidity*
 - *“Cog-wheeling” rigidity*
 - *“Lead-pipe” rigidity*
 - *Lack of arm swing with walking*
 - *Slowness of movement (bradykinesia)*

Perform a Neurological Examination

Perform a comprehensive neurological examination that must include each of the following twelve elements, though some elements have been described in other sections:

1. Describe general appearance and presentation (*see Describe Claimant’s General Appearance and Presentation*).
- 2.
3. Examine cranial nerve function, including:
 - » Pupillary responses (III) (*see Examine the Head, Eyes, Ears and Throat*)
 - » Extraocular muscle movements (III, IV, VI) (*see Examine the Head, Eyes, Ears and Throat*)
 - » Visual acuity (II) (*see Examine the Head, Eyes, Ears and Throat*)
 - » Visual fields by confrontation (II)
 - » Facial sensation (V)
 - » Facial symmetry (VII)
 - » Hearing and understanding of conversational speech (VIII)
 - » Gag reflex (IX)
 - » Shoulder shrug (XI)
 - » Tongue extension (XII)
8. Observe any muscular atrophy and measure the circumference of the forearms, arms, thighs and legs if there is any suspicion of it (*see Examine the Extremities and Ranges of Motion*). Record the data on the *Manual Muscle Testing section of the Neuromuscular Data Sheet (Part II - Appendix B)*.
9. Elicit deep tendon reflexes (see below) and record results for each reflex on each side:
 - » Brachioradialis
 - » Biceps
 - » Triceps
 - » Knee
 - » Ankle

10. Test each of these sensory modalities:

- » Light touch
- » Pain sensation (pin prick)
- » Proprioception (great toe positioning)
- » Vibratory sensation

11. Test cerebellar function by:

- » Assessing gait for ataxia or unsteadiness
- » Finger-to-nose test
- » Heel-to-shin test
- » Rapid alternating movements
- » Romberg Test with eyes open and with eyes closed

12. Observe and report any abnormal movements such as:

- » Tremor
- » "Pill-rolling"
- » Tics
- » Chorea
- » Athetosis
- » Fasciculations

Examine the Skin

Describe in detail any of the following findings, if present:

- Foot or leg ulcers
- Surgical wounds that are not completely healed
- Open wounds of any kind
- Amputee stump abnormalities
- Rashes
- Abnormal skin findings such as sclerodactyly of scleroderma
- Finger tip ulcers as in scleroderma or lupus
- Cutaneous findings of Raynaud's phenomenon
- Gangrenous portions of the feet or elsewhere
- Healed surgical scars

With rashes, DDD needs to know if there is involvement of these crucial areas:

- Feet
- Hands
- Inguinal region
- Perineal and perianal regions
- Axillae

Review Medical Records from DDD

- If DDD has medical records for the claimant, the agency will send you some of the most pertinent records.

- Document key findings such as abnormal MRI findings in your report and incorporate these results in your clinical assessment, diagnostic impressions (*see List All of Your Diagnostic Impressions*) and functional statement (*see Provide a Functional Statement ("Medical Source Statement")*).

Review Results of X-Rays or Other Tests Performed in Your Office

- If you have performed X-rays or pulmonary function tests, for example, document the main results briefly in your narrative report.
- Incorporate these results in your clinical assessment, diagnostic impressions (*see List All of Your Diagnostic Impressions*) and functional statement (*see Provide a Functional Statement ("Medical Source Statement")*).

List All of Your Diagnostic Impressions

- This is a key element of the consultative examination and report.
- Include confirmed diagnoses and "probable" diagnoses.
 - » For example, if someone has a long smoking history, progressive dyspnea, and greatly diminished breath sounds, he or she likely has COPD. In this situation state, "Probable COPD."
 - » Other commonly seen "probable" diagnoses include:
 - *Probable osteoarthritis of the knee*
 - *Probable osteoarthritis of the lumbar spine*
 - *Probable peripheral neuropathy*
 - *Probable angina*
 - *Probable fibromyalgia or myofascial pain syndrome*
 - *Probable rotator cuff tendonitis or partial tear*
 - *Probable claudication*
 - *Probable stroke in the past.*

Provide a Functional Statement ("Medical Source Statement")

- This is an "educated estimate" of ability to physically function in the workplace for eight hours per day, five days per week.
- DDD realizes that you do not have the availability of every test to help you; that is why it is described as an "educated estimate."
- Use all of the data you do have, including the history, examination results, any X-rays or other tests done in your office (if applicable) and any medical records provided by DDD.

- What is most important is that you do a reasonable and realistic assessment of function based on everything you know or have discovered about the claimant's medical illnesses and functional status.
- Include the effects of symptoms if there are plausible underlying medical conditions that likely cause them. For example, take a claimant with a known past history of severe coronary artery disease. If this claimant gives a cogent history of angina, it is appropriate to conclude he or she has probable angina and further, to restrict him from doing heavy or medium work based on a classic history in a high risk claimant.
- Some important functional capacities include educated estimates of how many hours during an eight hour workday a claimant can be on his or her feet (that is, stand and/or walk). Another important functional assessment is an estimate of how much weight a claimant can lift and carry for more than two hours per day ("occasionally" indicates up to a third of an eight hour day, and "frequently" indicates up to two-thirds of an eight hour day).

State Whether the Claimant Can Safely Undergo an Exercise Test

- Use all available historical, examination and test results to determine if an exercise stress test is contraindicated.
- Shown are some, but not all, of the contraindications to an exercise stress test for disability determination purposes:
 - » Difficulty walking
 - » Difficulty balancing
 - » Significant mental retardation, cognitive impairment, or mental illness
 - » Acute myocardial infarction in the past three months
 - » Unstable angina (any rest or nocturnal pain believed to be angina)
 - » Aortic stenosis
 - » Significant heart failure (all class IV and some class III)
 - » Aortic dissection
 - » Pulmonary embolus
 - » Pulmonary hypertension
 - » Left main coronary artery stenosis
 - » Electrolyte imbalance
 - » Severe hypertension
 - » Tachydysrhythmias
 - » Bradydysrhythmias
 - » Hypertrophic cardiomyopathy
 - » High grade A-V block

Enter the Manual Muscle Testing Results in the Neuromuscular Data Sheet (Part II - Appendix B)

- Do not delegate this to anyone other than a licensed physical or occupational therapist, physician assistant or nurse-practitioner.
- This form must be completed in its entirety, signed and returned to DDD for every claimant. Testing details are given within the *Manual Muscle Testing section of the Neuromuscular Data Sheet (Part II - Appendix B)*.

Enter the Range of Motion Testing Results in the Neuromuscular Data Sheet (Part II - Appendix B)

- Do not delegate this to anyone else other than a licensed physical or occupational therapist, physician assistant, or nurse-practitioner.
- This form must be completed in its entirety, signed and returned to DDD for every claimant. Testing details are given within the *Range of Motion Testing section of the Neuromuscular Data Sheet (Part II - Appendix B)*.

1151 Form

- In some claims that have been appealed, an administrative law judge will request an *1151 Form (Part II - Appendix D)*, which should be included in your packet. If it is requested on the voucher but not in the packet, *contact DDD*.
- An extra fee is paid for completion of a requested *1151 Form (Part II - Appendix D)*. The form is self-explanatory.
- The same principles stated under *Provide a Functional Statement ("Medical Source Statement")* should be used in completing the 1151. A copy of an *1151 Form* can be found in Part II - Appendix D.

Proofread

Signature

Sign the report personally. Stamps, electronic signatures or signatures by persons other than the consultative physician are not permitted.

Part II Appendices

- A. Examples of Key Questions for Four Common Chief Complaints
- B. Neuromuscular Data Sheet
- C. Common Gait Abnormalities
- D. 1151 Form

Part II - Appendix A: Examples of Key Questions for Four Common Chief Complaints

Chest Discomfort or Pain

- Where is the pain? What is it like? How long does it last? What brings it on? If it is exertional, at what levels of exertion does it occur? What relieves it? How many times do you have it a month or week?
- Have you had to go to the emergency department for chest pain? What were you diagnosed with? A heart attack? Unstable angina? Were you admitted? For how long?
- Have you ever had a cardiac catheterization? When? Do you know the results? Have you had angioplasty or stenting? When? Have you had bypass surgery? When?
- Have you ever been told you had heart failure? Have you ever had an echocardiogram? When? Do you know the results?
- Do you have an implantable defibrillator or pacemaker?

Note: If, in your opinion, a definite or probable heart disease (such as angina) is present, list this in your impressions diagnoses near the end of your report.

Shortness of Breath

- How long have you been short of breath? Has it gotten worse with time?
- How far can you walk on level ground before having to stop due to shortness of breath?
- How many stairs can you climb before having to stop due to shortness of breath?
- Do you have any known lung diseases? Asthma, COPD, fibrosis?
- Have you had any pulmonary function tests? When? Where? Do you know what the results were?
- Have you had any chest X-rays or chest CT scans? Do you know the results?
- Do you use oxygen? All the time? Part of the time? How long have you been on oxygen?
- Have you had to go to the emergency department for trouble breathing? When? Where? Were you admitted? Were you placed on a ventilator?

Note: if, in your opinion, a definite or probable lung disease is present, list this in your impressions or diagnoses near the end of the report.

Back Pain

- Where is the pain?
- Does it stay in the back or extend to the legs? If so how far down the leg or legs?
- When did you first start having back pain?
- Does anything make the pain better?
- Does anything make the pain worse?
- Has anyone ever evaluated your back pain? If so, what was found? What were the results of any back X-rays or MRIs?
- Has back surgery ever been recommended?
- Have you ever had back surgery? Do you know specifically what was done? When did you have surgery?
- Do you ever lose control of your bowels or bladder?
- If back pain occurs with walking, how far can you walk without having to stop due to back pain?

Note: If, in your opinion, a definite or probable spine disease is present, list this in your impressions or diagnoses near the end of your report.

Knee Pain

- Where is the pain?
- When did the pain start?
- Was there an injury prior to the onset of the knee pain? If so, what?
- Does anything make the pain better?
- Does anything make the pain worse?
- Has anyone ever evaluated your knee pain? If so, what was found? What were the results of any knee X-rays or MRIs?
- Has knee surgery ever been recommended?
- Have you ever had knee surgery or arthroscopy? Do you know what was found and/or what was done? When did you have surgery or arthroscopy?
- Does your knee pain affect walking? Affect stair climbing?
- How far can you walk without stopping?
- Do you use an ambulatory aid? What aid? Do you use it outdoors? Indoors? How long have you been using it? Who prescribed it? When?

Note: if, in your opinion, a definite or probable knee or other joint disease (such as osteoarthritis) is present, list this in your impressions or diagnoses near the end of your report.

Part II - Appendix B: Neuromuscular Data Sheet

Telephone: 800-282-2690

Claimant: John A. Smith

A/N: ###-##-####

Case: 1234567

MANUAL MUSCLE TESTING

USE THE FOLLOWING SCALE FOR REPORTING YOUR MOTOR FINDINGS:

0 = absent: no movement, no palpable muscle contraction.	3 = fair: can raise part against gravity only.
1 = trace: muscle can be felt to tighten, but cannot produce movement.	4 = good: can raise part against minimal/moderate resistance as well as against gravity.
2 = poor: produces movement with gravity eliminated, but cannot function against gravity.	5 = normal can raise part against maximal resistance.

(IF ALL ARE NORMAL, WRITE "5" ONE TIME AT THE TOP OF THE TABLE AND DRAW AN ARROW DOWN)

	RIGHT	LEFT		RIGHT	LEFT
SHOULDER ABDUCTORS	_____	_____	HIP FLEXORS	_____	_____
SHOULDER EXTERNAL ROTATORS	_____	_____	HIP EXTENSORS	_____	_____
SHOULDER INTERNAL ROTATORS	_____	_____	KNEE FLEXORS	_____	_____
ELBOW FLEXORS	_____	_____	KNEE EXTENSORS	_____	_____
ELBOW EXTENSORS	_____	_____	FOOT DORSIFLEXORS	_____	_____
WRIST FLEXORS	_____	_____	FOOT PLANTARFLEXORS	_____	_____
WRIST EXTENSORS	_____	_____	FOOT INVERTORS	_____	_____
FINGER ABDUCTORS	_____	_____	FOOT EVERTORS	_____	_____
FINGER ADDUCTORS	_____	_____	GREAT TOE EXTENSORS	_____	_____

DESIGNATE BY AN "X" THE FOLLOWING FUNCTIONS

	RIGHT		LEFT			RIGHT	LEFT
	NORMAL	ABNORMAL	NORMAL	ABNORMAL	DYNAMOMETER READINGS X 3 (Required for musculoskeletal, neurological & phys/occupational functional exams; suggested for internal medical exams).	RIGHT	LEFT
GRASP	_____	_____	_____	_____		_____	_____
MANIPULATION	_____	_____	_____	_____		_____	_____
PINCH	_____	_____	_____	_____		_____	_____
FINE COORDINATION	_____	_____	_____	_____		_____	_____

DOMINANT HAND: RIGHT HAND LEFT HAND

I consider the above muscle testing RELIABLE NOT RELIABLE If not, describe why:

DESCRIBE ANY ABNORMALITIES NOTED ABOVE (SPECIFICALLY, INDICATE ABILITY TO PICK UP LARGE AND SMALL OBJECTS, AND GIVE EXAMPLES OF WHAT THE CLAIMANT CAN AND CANNOT DO, SUCH AS WRITE, KEY, PICK UP A COIN, HOLD A COFFEE CUP, ZIPPER, BUTTON/UNBUTTON, OPEN A JAR, ETC.)

DESCRIBE ABILITY TO PICK UP A COIN, KEY, WRITE, HOLD A CUP, OPEN A JAR, BUTTON/UNBUTTON, ZIPPER, OPEN A DOOR.

Muscle spasm WAS WAS NOT present. If present, describe location and degree and distinguish between involuntary spasm and voluntary guarding.

Was spasticity, clonus, or primitive reflexes present? YES NO
 If present, describe:

Muscle atrophy WAS WAS NOT present. If present, give circumferential measurements of upper arms and forearms, thighs and calves, as per below:

UPPER ARM _____ RIGHT _____ LEFT THIGH _____ RIGHT _____ LEFT
 FOREARM _____ RIGHT _____ LEFT CALF _____ RIGHT _____ LEFT
 _____ INCHES ABOVE AND BELOW ELBOW _____ INCHES ABOVE AND BELOW KNEE

RANGE OF MOTION (ROM)

NUMERICAL ENTRIES IN THE FOLLOWING TABLES REPRESENT JOINT MOTION IN DEGREES

CERVICAL SPINE	NORMALS	
FLEXION	50°	
EXTENSION	60°	
RIGHT LATERAL FLEXION	45°	
LEFT LATERAL FLEXION	45°	
RIGHT ROTATION	80°	
LEFT ROTATION	80°	

SHOULDER	NORMALS	RIGHT ACTIVE	RIGHT PASSIVE	LEFT ACTIVE	LEFT PASSIVE
FLEXION	180°				
EXTENSION	50°				
ABDUCTION	180°				
ADDUCTION	50°				
INTERNAL ROTATION	90°				
EXTERNAL ROTATION	90°				

ELBOW	NORMALS	RIGHT ACTIVE	RIGHT PASSIVE	LEFT ACTIVE	LEFT PASSIVE
FLEXION	140°				
EXTENSION	0°				
SUPINATION	80°				
PRONATION	80°				

WRIST	NORMALS	RIGHT ACTIVE	RIGHT PASSIVE	LEFT ACTIVE	LEFT PASSIVE
DORSIFLEXION	60°				
PALMAR FLEXION	60°				
RADIAL DEVIATION	20°				
ULNAR DEVIATION	30°				

HANDS-FINGERS	FLEXION		EXTENSION			FLEXION		EXTENSION			
	NORMAL 90°		NORMAL 0°			NORMAL 120°		NORMAL 0°			
	RIGHT	LEFT	RIGHT	LEFT		RIGHT	LEFT	RIGHT	LEFT		
MCP JOINTS	1					X	X	X	X		
	2				PIP	2					
	3					3					
	4					4					
	5					5					
NOTE:FOR AREAS ALLEGED TO BE SYMPTOMATIC THE TABLES MUST HAVE NUMERICAL ENTRIES, EVEN IF "NORMAL" ON EXAM. WHERE ACTIVE ROM IS ABNORMAL TEST PASSIVE ROM FOR AREASOTHER THAN THE SPINE OR HANDS-FINGERS.						NORMAL 70°		NORMAL 0°			
								RIGH	LEFT	RIGH	LEFT
								T		T	
							IP	1			
							DIP	2			
								3			
		4									
		5									

RANGE OF MOTION (ROM)

NUMERICAL ENTRIES IN THE FOLLOWING TABLES REPRESENT JOINT MOTION IN DEGREES

FOR OBESE INDIVIDUALS, THE TABLES BELOW MUST HAVE NUMERICAL ENTRIES.

DORSOLUMBAR SPINE	NORMALS	
FLEXION	90°	
EXTENSION	30°	
RIGHT LATERAL FLEXION	30°	
LEFT LATERAL FLEXION	30°	

HIP	NORMALS	RIGHT ACTIVE	RIGHT PASSIVE	LEFT ACTIVE	LEFT PASSIVE
FLEXION	100°				
EXTENSION	30°				
ABDUCTION	40°				
ADDUCTION	20°				
INTERNAL ROTATION	40°				
EXTERNAL ROTATION	50°				

KNEE	NORMALS	RIGHT ACTIVE	RIGHT PASSIVE	LEFT ACTIVE	LEFT PASSIVE
FLEXION	150°				
EXTENSION	0°				

ANKLE	NORMALS	RIGHT ACTIVE	RIGHT PASSIVE	LEFT ACTIVE	LEFT PASSIVE
DORSIFLEXION	20°				
PLANTAR FLEXION	40°				
INVERSION	30°				
EVERSION	20°				

IT IS STRONGLY RECOMMENDED THAT A GONIOMETER BE USED TO ASSESS RANGE OF MOTION FOR THESE TABLES

REMARKS: _____

 PRINTED NAME

 SIGNATURE

 DATE

Part II - Appendix C: Common Gait Abnormalities

Adopted from DeGowin's Diagnostic Examination, 9th edition (2009), Chapter 14

Gait is a complex activity requiring normal sensory input from the feet, spinal cord, and vestibular system, and normal motor and cerebellar function. Impairments in any of these systems leads to characteristic changes in the gait. Careful inspection of gait can greatly aid identification of the site of the lesion.

Cerebellar Ataxia: The gait is staggering, wavering, and lurching walk and not visually compensated. With a lesion in the mid-cerebellum, instability is in all directions; when one lobe is involved, staggering is toward the affected side. The ataxia is partially compensated by a wide base. Ataxia secondary to vestibular disease may appear similar.

Impaired Proprioception: The gait and stance are facilitated by a wide stance. In walking, the feet are lifted too high, and frequently are set down with excessive force. The eyes are used to compensate for loss of proprioception, so the ataxia is much greater with the eyes closed. The lesion may be in peripheral sensory nerves (e.g., diabetes) or posterior column of the spinal cord (e.g., vitamin B12 or copper deficiency, tabes dorsalis); in either case, proprioceptive impulses to the brain are defective.

Foot Drop (Steppage Gait): Paralysis of the ankle dorsiflexors causes the foot to slap down onto the floor. To compensate for the toe drop, the patient must raise the thigh higher, as if walking upstairs. Unilateral toe drop usually results from injury of the peroneal nerve. Bilateral paralysis may occur from polyneuropathies, poliomyelitis, lesions of the cauda equina, or peroneal atrophy in Charcot-Marie-Tooth disease.

Peroneal Muscular Atrophy / Charcot-Marie-Tooth Disease: This is a hereditary disease of unknown cause. Presenting symptoms are foot drop, pain, weakness, numbness and paresthesias of the lower legs. The syndrome is slowly progressive with clawfoot and foot drop, from weak peronei, tibialis anterior, and extensor longus digitorum. Muscle stretch reflexes are absent and there is cutaneous hypesthesia and the steppage gait. The forearm may be affected.

Hemiplegic Gait: The patient walks with the affected lower limb extended at the hip, knee, and ankle, and the foot inverted. The thigh may swing in a lateral arc (circumduction) or the patient may push the inverted foot along the floor.

Spastic Gait, Scissors Gait: In paraparesis with adductor spasm, the knees are pulled together so the body must sway laterally away from the stepping limb to allow it to clear the floor. The feet may overstep each other laterally, alternately crossing across the line of travel with each step.

Parkinsonian Gait (Festinating Gait): The trunk and neck are rigid and flexed. The arm swing is diminished or lost unilaterally or bilaterally. The steps are short and shuffling and become faster in an attempt to avoid falling forward (chasing the center of gravity: festination). Turns are slow and in-block, without evident turning of the head on the trunk or the trunk on the pelvis.

Magnetic Gait: The stance is wide and the steps are short and shuffling. The feet are not lifted from the floor, as if held down by magnets. This indicates diffuse cerebral disease or multisystem damage.

Huntington Chorea: Walking is attended by grotesque movements caused by the interposition of purposeless involuntary chorea on gait movements.

Waddling Gait (Muscular Dystrophy): The patient walks with a broad base. The thighs are thrown forward by twisting the pelvis to compensate for the weak quadriceps muscles. A similar gait is employed by those with bilateral dislocations of the hips.

**MEDICAL SOURCE STATEMENT OF
ABILITY TO DO WORK-RELATED ACTIVITIES (PHYSICAL)**

NAME OF INDIVIDUAL

SOCIAL SECURITY NUMBER

- -

To determine this individual's ability to do **work-related activities on a regular and continuous basis**, please give us your opinions for each activity shown below:

The following terms are defined as:

- **REGULAR AND CONTINUOUS BASIS** means 8 hours a day, for 5 days a week, or an equivalent work schedule.
- **OCCASIONALLY** means very little to one-third of the time.
- **FREQUENTLY** means from one-third to two-thirds of the time.
- **CONTINUOUSLY** means more than two-thirds of the time.

Age and body habitus of the individual should not be considered in the assessment of limitations. It is important that you relate particular medical or clinical findings to any assessed limitations in capacity: The usefulness of your assessment depends on the extent to which you do this.

I. LIFTING/CARRYING

Check the boxes representing the amount the individual can lift and how often it can be lifted.

Lift	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)
A. Up to 10 lbs:				
B. 11 to 20 lbs:				
C. 21 to 50 lbs:				
D. 51 to 100 lbs:				

Check the boxes representing the amount the individual can carry and how often it can be carried.

Carry	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)
A. Up to 10 lbs:				
B. 11 to 20 lbs:				
C. 21 to 50 lbs:				
D. 51 to 100 lbs:				

Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain, etc.) which support your assessment or any limitations and why the findings support the assessment.

II. SITTING/STANDING/WALKING

Please check how many hours the individual can (if less than one hour, how many minutes):

At One Time without Interruption

	<u>Minutes</u>	<u>Hours</u>							
A. Sit	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8
B. Stand	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8
C. Walk	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8

Total in an 8 hour work day

	<u>Minutes</u>	<u>Hours</u>							
A. Sit	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8
B. Stand	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8
C. Walk	_____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8

If the total time for sitting, standing and walking does not equal or exceed 8 hours, what activity is the individual performing for the rest of the 8 hours?

Does the individual require the use of a cane to ambulate? Yes No

If the answer is "yes" please answer the following:

- How far can the individual ambulate without the use of a cane? _____
- Is the use of a cane medically necessary? Yes No
- With a cane, can the individual use his/her free hand to carry small objects? Yes No

Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain etc.) which support your assessment or any limitations and why the findings support the assessment.

III. USE OF HANDS

Indicate how often the individual can perform the following activities:

ACTIVITY	Right Hand				Left Hand			
	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)
REACHING (Overhead)								
REACHING (All Other)								
HANDLING								
FINGERING								
FEELING								
PUSH/PULL								

Which is the individual's dominant hand? Right Hand Left Hand

Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain, etc.) which support your assessment or any limitations and why the findings support this assessment.

IV. USE OF FEET

Indicate how often the individual can perform the following activities:

ACTIVITY	Right Foot				Left Foot			
	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)
Operation of Foot Controls								

Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain, etc.) which support your assessment or any limitations and why the findings support the assessment.

V. POSTURAL ACTIVITIES

How often can the individual perform the following activities:

ACTIVITY	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)
Climb stairs and ramps				
Climb ladders or scaffolds				
Balance				
Stoop				
Kneel				
Crouch				
Crawl				

Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain etc.) which support your assessment or any limitations and why the findings support the assessment.

VI. DO ANY OF THE IMPAIRMENTS AFFECT THE CLAIMANT'S HEARING OR VISION?

No Yes Not Evaluated

If "yes" please complete the following questions (where appropriate)

1. If a **hearing impairment** is present,
 - a. Does the individual retain the ability to hear and understand simple oral instructions and to communicate simple information? Yes No
 - b. Can the individual use a telephone to communicate? Yes No
2. If a **visual impairment** is present,
 - a. Is the individual able to avoid ordinary hazards in the workplace, such as boxes on the floor, doors ajar, or approaching people or vehicles? Yes No
 - b. Is the individual able to read very small print? Yes No
 - c. Is the individual able to read ordinary newspaper or book print? Yes No
 - d. Is the individual able to view a computer screen? Yes No
 - e. Is the individual able to determine differences in shape and color of small objects such as screws, nuts or bolts? Yes No

Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain etc.) which support your assessment or any limitations and why the findings support the assessment.

VII. ENVIRONMENTAL LIMITATIONS

How often can the individual tolerate exposure to the following conditions:

Condition	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)
Unprotected Heights				
Moving Mechanical Parts				
Operating a motor vehicle				
Humidity and wetness				
Dust, odors, fumes and pulmonary irritants				
Extreme cold				
Extreme heat				
Vibrations				
Other: (Identify)				

Condition	Quiet (Library)	Moderate (Office)	Loud (Heavy Traffic)	Very Loud (Jackhammer)
Noise				

Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain, etc.) which support your assessment or any limitations and why the findings support the assessment.

VIII. PLEASE PLACE A CHECK IN APPROPRIATE BOXES BASED SOLELY ON THE CLAIMANT'S PHYSICAL IMPAIRMENTS

ACTIVITY	YES	NO
Can the individual perform activities like shopping?		
Can the individual travel without a companion for assistance?		
Can the individual ambulate without using a wheelchair, walker, or 2 canes or 2 crutches?		
Can the individual walk a block at a reasonable pace on rough or uneven surfaces?		
Can the individual use standard public transportation?		
Can the individual climb a few steps at a reasonable pace with the use of a single hand rail?		
Can the individual prepare a simple meal & feed himself/herself?		
Can the individual care for their personal hygiene?		
Can the individual sort, handle, or use paper/files?		

Please identify the medical findings that support this assessment and why the findings support the assessment (unless a narrative report is attached).

IX. STATE ANY OTHER WORK-RELATED ACTIVITIES, WHICH ARE AFFECTED BY ANY IMPAIRMENTS, AND INDICATE HOW THE ACTIVITIES ARE AFFECTED. WHAT ARE THE MEDICAL FINDINGS THAT SUPPORT THIS ASSESSMENT?

X. THE LIMITATIONS ABOVE ARE ASSUMED TO BE YOUR OPINION REGARDING CURRENT LIMITATIONS ONLY.

HOWEVER, IF YOU HAVE SUFFICIENT INFORMATION TO FORM AN OPINION WITHIN A REASONABLE DEGREE OF MEDICAL PROBABILITY AS TO PAST LIMITATIONS, ON WHAT DATE WERE THE LIMITATIONS YOU FOUND ABOVE FIRST PRESENT? _____

XI. HAVE THE LIMITATIONS YOU FOUND ABOVE LASTED OR WILL THEY LAST FOR 12 CONSECUTIVE MONTHS? Yes No

SIGNATURE

DATE

Print Name, Title and Medical Specialty (Legibly Please)

Privacy Act Statement

Collection and Use of Personal Information

Sections 205(a), 223(d), 1614(a)(3)(H)(I) and 1631(d)(1) of the Social Security Act, as amended, authorize us to collect this information. The information you provide will be used to complete processing of the named patient's claim.

The information you furnish on this form is voluntary. However, failure to provide the requested information may prevent an accurate or timely decision on the named patient's claim.

We rarely use the information you supply for any purpose other than for determining eligibility for benefits. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, state and local level; and
4. To facilitate statistical research, audit or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, state or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and our programs and systems, is available on-line at www.ssa.gov or at your local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 15 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE.** The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.