

***CROHN'S & COLITIS 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. Diagnoses: \_\_\_\_\_

3. Prognosis: \_\_\_\_\_

4. Identify your patient's symptoms:

- |                                                      |                                                         |
|------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Chronic diarrhea            | <input type="checkbox"/> Anal fissures                  |
| <input type="checkbox"/> Bloody diarrhea             | <input type="checkbox"/> Nausea                         |
| <input type="checkbox"/> Abdominal pain and cramping | <input type="checkbox"/> Peripheral arthritis           |
| <input type="checkbox"/> Fever                       | <input type="checkbox"/> Kidney problems                |
| <input type="checkbox"/> Weight loss                 | <input type="checkbox"/> Malaise                        |
| <input type="checkbox"/> Loss of appetite            | <input type="checkbox"/> Fatigue                        |
| <input type="checkbox"/> Bowel obstruction           | <input type="checkbox"/> Mucus in stool                 |
| <input type="checkbox"/> Vomiting                    | <input type="checkbox"/> Ineffective straining at stool |
| <input type="checkbox"/> Abdominal distention        | (rectal tenesmus)                                       |
| <input type="checkbox"/> Fistulas                    | <input type="checkbox"/> Sweatiness                     |

Other: \_\_\_\_\_

5. If your patient has pain, characterize the nature, location, frequency, precipitating factors, and severity of your patient's pain:

\_\_\_\_\_  
\_\_\_\_\_

6. If aspects of your patient's impairment are episodic, describe the nature, precipitating factors, severity, frequency and duration of the episodic aspects:

\_\_\_\_\_  
\_\_\_\_\_

7. Identify the clinical findings and objective signs:

\_\_\_\_\_  
\_\_\_\_\_



2) how **long** will your patient be away from the work station for an average unscheduled restroom break? \_\_\_\_\_

3) how much advance notice does your patient have of the need for a restroom break? \_\_\_\_\_

h. Will your patient also sometimes need to lie down or rest at unpredictable intervals 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? \_\_\_\_\_

*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.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

	Never	Rarely	Occasionally	Frequently
Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stoop (bend)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crouch/ squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb ladders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

k. 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

l. 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: \_\_\_\_\_

m. 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 three days per month  
 About one day per month  About four days per month  
 About two days per month  More than four days per month

13. 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: \_\_\_\_\_

14. Please describe any other limitations (such as limitations using hands, arms, fingers, 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:* \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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