SOFT TISSUE INJURIES TREATING PHYSICIAN DATA SHEET

Short form

FOR REPRESENTATIVE USE ONLY						
REPRESENTATIVE'S NAME AND ADDRESS		REPRESENTATIVE'S TELEPHONE				
		REPRESENTATIVE'S EMAIL				
Physician's NA	AME AND ADDRESS	PHYSICIAN'S TELEPHONE				
		Physician's Email				
		PATIENT'S TELEPHONE				
PATIENT'S NAM	E AND ADDRESS	PATIENT'S EMAIL				
		PATIENT'S SSN				
		LEVEL OF ADJUDICATION:				
		Initial DDS 🗌 Recon DDS 🗌				
TYPE OF CLAIM:		Initial CDR 🗌 Hearing Officer				
Title 2		Administrative Law Judge	Appeals Council			
Title 16		Federal District Court	Federal Appeals Court			

Dear Dr.

We are pursuing the Social Security disability claim for the above-named individual (the "patient"). We understand how valuable your time is, and this data sheet has been designed to allow you to provide medical information in an efficient and organized way. As a treating physician, your records and medical judgment are vital in arguing for a fair disability determination for the patient before the Social Security Administration (SSA). If you receive multiple data sheets, please disregard repetitive questions.

Your medical specialty please:

<u>Note 1</u>: This document will not have legal validity for Social Security disability determination purposes unless completed by a licensed medical doctor or osteopath.

<u>Note 2</u>: This document only concerns soft tissue injuries. Other impairments and limitations resulting from a combination of impairments should be considered separately.

<u>Note 3</u>: Age, degree of general physical conditioning, sex, body habitus (i.e., natural body build, physique, constitution, size, and weight), insofar as they are unrelated to the patient's medical disorder and symptoms, should not be considered when assessing the functional severity of the impairment.

"Occasionally" means very little up to 1/3 of an 8 hour workday.

"Frequently" means 1/3 to 2/3 of an 8 hour workday.

I. What is the date of the soft tissue injury?

Date:

II. Are there associated fractures?

Yes No Unknown

If **Yes**, please complete Forms 1.06 or 1.07 for lower or upper extremity fractures, respectively, disregarding any duplicative questions with this Form 1.08.

III. What is the cause of the soft tissue injury?

Trauma
Burn
Radiation
Infection
Other

IV. Describe the location of the soft tissue injury.

A. Head	☐ Yes	🗌 No
If Yes, what structures were damaged?		
B. Trunk	🗌 Yes	🗌 No
If Yes , what structures were damaged?		
1. 🗌 Skin (please describe)		
2. 🗌 Internal organs (please describ	e)	
3.	ease desc	ribe)
C. Extremities		
1. Which extremity		

2. Please specify the extremity, as well as the nature of any neurological, vascular, muscle, or other soft tissue injury (attach operative notes if available). In the case of burns, please note any contractures or scarring affecting joint mobility.

V. Treatment and recovery

Note: The limiting effects of pain or other symptoms should be included in assessment of functional loss.

A. Head injuries

Is there functional loss in any of the following areas to the extent that the patient would be unable to carry out major activities of daily living, such as self-care and communication?

🗌 Vision	
🗌 Hearing	
🗌 Speech	
Chewing	or swallowing
Brain	-

B. Is the patient under continuing surgical management directed toward salvage or restoration of functional use of the injured limb or other body part?

Yes 🗌	🗌 No	🗌 Unknown
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If **Yes**, please describe the nature of such management (including any vascular or nerve grafts, treatment for burn scars and joint contractures, and post-surgical procedures).

Has major function been restored <u>or expected to be restored</u> within 12 months post-injury?

If **No**, please explain and list specific surgical management that is expected to require at least 12 months to restore **major function** in the affected soft tissues. (For example, inability to play a musical instrument is not loss of basic hand function, but severe impairment of the ability to grasp would be such a loss.)

VI. The patient's limitations and capacities expected 12 months post-injury

Note 1: The limiting effects of pain or other symptoms should be included in assessment of functional loss.

<u>Note 2</u>: Even if the patient is not 12 months post-injury, please answer the following questions with your best estimate of the claimant's medical function at 12 months post-injury.

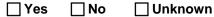
Note 3: If the patient uses any type of orthotic or prosthetic device, questions pertain to function while using such devices.

A. Lower extremity function (adults and children)

Can the patient ambulate without the use of a hand-held assistive device that limits the functioning of both upper extremities?

Yes No Unknown

Can the patient sustain a reasonable walking pace over a sufficient distance to be able to carry out activ	vities of
daily living?	



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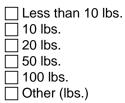
Do	es the patient have the ability to	o travel with	nout compa	anion assistance to and from work or school?
	es the patient require bilateral u lker?	upper limb a	assistive de	evices, such as two crutches, two canes, or a
		🗌 Yes	🗌 No	Unknown
lst	the patient able to walk one bloc	ck at a reas	sonable pao No	ce on rough or uneven surfaces?
ls t	the patient able to use standard	public tran	sportation?	? Unknown
lst	the patient able to carry out rout	tine ambula	atory activit	ies, such as shopping and banking?
lst	the patient able to climb a few s	teps at a re	easonable p	bace using a single handrail?
Otl	her marked limitation (please sp	becify)		
Does the p		, function in l		extremities, to the extent that the ability to ability to ability to independently initiate, sustain, or
complete a	ctivities?	🗌 Yes	🗌 No	Unknown
<u>For e</u>	xample:			
lst	the patient able to prepare a me	eal and feed Yes	d himself oi	r herself? Unknown
lst	the patient able to take care of p	personal hy	giene? □ No	Unknown
lst	the patient able to sort and hand	dle papers	or files?	Unknown
lst	the patient able to place files in	a file cabin	et at or abo	ove waist level?
Otl	her marked limitation (please sp	becify)		
C. Specific resid	dual functional capacities and lir	mitations (v	vork-related	d functions for adults only)

Note: The following questions apply only to patients at least 18 years of age. For children, please see Section VII.

1. Does the patient have the ability to stand and/or walk 6 - 8 hours daily on a long term basis? 🗌 Yes **□** No Unknown

If No, how long can the patient stand and/or walk (with normal breaks) in a 6 - 8 hour work day?

2. What maximum weight can the patient lift and/or carry occasionally (cumulatively not continuously)?



3. What weight can the patient lift and/or carry frequently (cumulatively not continuously)?

Less than 10 lbs.
 10 lbs.
 20 lbs.
 50 lbs. or more
 Other (lbs.)

4. Work environment temperature restrictions

Would the patient's exertional capacities for lifting and carrying (as described in 2 and 3 above) be further reduced by work in extremely hot or cold environments?

🗌 Yes	🗌 No
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Unknown

5. Specific types of function

a. Can the following activities be performed?

Pushing or pulling: Right arm:				
Climbing: Ladders:				
Overhead work: Right arm: never coccasionally frequently unknown Left arm: never coccasionally frequently unknown				
Hand controls: Right hand:				
Leg controls: (repetitive force must be applied with leg) Right leg:				
Squatting:				
Kneeling: never coccasionally frequently unknown				
Crawling:				
Crouching: never ? occasionally frequently unknown				
b. Does the claimant have impairment in balance as a result of lower extremity disease, injury, or reconstructive surgery? Yes No Unknown				
c. Fine manipulatory ability				
 Does the patient have limitations in the ability to perform fine manipulations (precise, coordinated, reasonably rapid use of the fingers)? 				
VII. For children under age 18 only.				
Note: The limiting effects of pain or other symptoms should be included in assessment of functional loss.				

Are the child's limitations described in Section	V, A and I	B above	abnormal for the o	child's age?
	🗌 Yes	🗌 No	🛛 🗌 Unknown	1

If you have other information regarding limitations in age-appropriate abilities, including developmental or other types of testing, please attach copies or discuss the results here.

VIII. Additional Physician Comments

Physician's Name (print or type)

Physician's Signature (no name stamps)

Date