Huntington's Disease Society of America

HUNTINGTON'S DISEASE MEDICAL SOURCE STATEMENT

Name: _____ DOB: _____ SSN: _____

Dear Dr. _____

We are pursuing a Social Security disability claim for the above-named individual (the "patient"). As a treating physician, your records and medical judgment are vital in arguing for a fair disability determination before the Social Security Administration (SSA).

Your medical specialty: _____

1. Please state the diagnosis of the problem that causes the patient's limitations and restrictions, as well as the objective, clinical, or other specific findings that support your diagnosis and opinion:

   _____

   _____

2. Frequency and length of contact: _____

3. Have the patient's impairments lasted, or can they be expected to last at least twelve months?

   ☐ Yes ☐ No

4. Prognosis: _____

5. Identify all of the patient's ***symptoms and signs***:

Involuntary movements (chorea)	☐ Yes ☐ No	Changes in sleep patterns	☐ Yes ☐ No
Trouble walking	☐ Yes ☐ No	Sadness	☐ Yes ☐ No
Clumsiness, imbalance	☐ Yes ☐ No	Depression	☐ Yes ☐ No
Unsteadiness	☐ Yes ☐ No	Lack of motivation	☐ Yes ☐ No
Trouble holding objects	☐ Yes ☐ No	Difficult to get along with	☐ Yes ☐ No
Speech difficulty	☐ Yes ☐ No	Sexual problems	☐ Yes ☐ No
Weight loss	☐ Yes ☐ No	Difficulty sleeping	☐ Yes ☐ No
Difficulty with bladder control	☐ Yes ☐ No	Memory loss	☐ Yes ☐ No
Difficulty with bowel control	☐ Yes ☐ No	Intellectual decline	☐ Yes ☐ No
Delusions or hallucinations	☐ Yes ☐ No	Suspiciousness, paranoia	☐ Yes ☐ No
Difficulty swallowing	☐ Yes ☐ No	Choking	☐ Yes ☐ No

6. List any other symptoms, signs, and clinical findings: _____

   _____

7. How severe are the symptoms suffered by the patient?

   ☐ Extreme ☐ Severe ☐ Moderately Severe ☐ Moderate ☐ Mild

8. Does the patient demonstrate a loss of specific cognitive abilities or affective changes and the medically-documented persistence of any of the following?

Disorientation to time and place	☐ Yes	☐ No	Memory impairment:		
Perceptual or thinking disturbances	☐ Yes	☐ No	Short term	☐ Yes	☐ No
Change in personality	☐ Yes	☐ No	Intermediate	☐ Yes	☐ No
Disturbance in mood	☐ Yes	☐ No	Long term	☐ Yes	☐ No
Emotional lability	☐ Yes	☐ No	Impulse Control Impairment	☐ Yes	☐ No

9. Rate your patient's mental limitations as a result of the neurological impairment using the following scale:

Mild means the ability to function independently, appropriately, effectively, and on a sustained basis, is slightly limited

Moderate means the ability to function independently, appropriately, effectively, and on a sustained basis, is fair.

Marked means the ability to function independently, appropriately, effectively, and on a sustained basis, is seriously limited.

Extreme means not able to function independently, appropriately, effectively, and on a sustained basis, but it does not mean a total loss of ability to function.

RATE THE DEGREE OF LIMITATION	None	Mild	Moderate	Marked	Extreme
Understanding information:					
Remembering information:					
Applying information:					
Interacting with others:					
Concentrating:					
Persisting:					
Maintaining pace:					
Adapting in the workplace:					
Managing oneself in the workplace:					

10. Is the patient limited in their ability to interact in any of the following ways in a work setting?
    - With the public ☐ Yes ☐ No
    - With supervisors ☐ Yes ☐ No
    - With coworkers ☐ Yes ☐ No

11. Does a minimal increase in mental demands or change in the environment cause the patient to decompensate?

☐ Yes ☐ No

12. Does the patient have a current history of one or more years' inability to function outside a highly-supportive living arrangement, with an indication of continued need for such an arrangement?

☐ Yes ☐ No

13. Does the patient have disorganization of motor function in two extremities resulting in an extreme limitation in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities? ☐ Yes ☐ No

If yes, please describe the degree of interference with locomotion and/or interference with the use of fingers, hands, and arms: _____
_____
_____

a. Does the patient need to use an assistive device to stand up from a seated position?

☐ Yes ☐ No

b. Does the patient need to use an assistive device to walk? ☐ Yes ☐ No

If yes, what type of assistive device is used?

☐ cane(s) ☐ crutches motorized scooter
walker wheelchair assistance of another person

14. Rate the degree to which you patient is physically limited:

◯ None ◯ Mild ◯ Moderate ◯ Marked ◯ Extreme

15. As a result of the patient's impairments, estimate the patient's functional limitations if the patient were placed in a ***competitive work environment:***

a. How many city blocks can the patient walk without rest or severe pain? _____

b. Please circle the hours and/or minutes that the patient can sit, stand, or walk ***at one time***

Sit: Minutes Hours

Stand: _____ Minutes Hours

Walk: _____ Minutes Hours

16. Please indicate how long **in total,** the patient can sit and stand/walk ***during an eight-hour working day*** (with normal breaks):

Sit	**Stand/walk**	
		less than 2 hours
		about 2 hours
		about 4 hours
		at least 6 hours

17. Does the patient need a job that permits shifting positions ***at will*** from sitting, standing or walking?

☐ Yes ☐ No

18. Will the 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 the 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: _____	

19. How many pounds can the patient lift and carry in a competitive work environment?

	Never	**Rarely (up to 3 hours)**	**Occasionally (3 to 6 hours)**	**Frequently (over 6 hours)**
10 lbs.				
11 to 20 lbs.				
21 to 50 lbs.				
51 to 100 lbs.				

20. How often can the patient perform the following activities?

	Never	**Rarely (up to 3 hours)**	**Occasionally (3 to 6 hours)**	**Frequently (over 6 hours)**
Reaching (overhead)				
Reaching (all other)				
Push/Pull				
Climb stairs and ramps				
Climb ladders or scaffolds				
Balance				
Stoop (bend)				
Kneel				
Crouch/Squat				
Crawl				
Twist				
List other activities: _____				

21. If the patient has significant limitations with reaching, handling or fingering: What symptoms cause limitations of use of the upper extremities?

Pain/ paresthesias	Incoordination	Chorea
Muscle weakness	Spasticity	Fatigue
Tremor	Other: _____	

Please indicate the percentage of time during an eight-hour working day that the 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:	**%**	**%**	**%**	**%**

22. How much is the patient likely to be **"*off task*"**? That is, what percentage of a typical workday would the 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

23. Do emotional factors contribute to the severity of the patient's symptoms and functional limitations?

☐ Yes ☐ No

24. Are the patient's impairments likely to produce "good days" and "bad days"?

☐ Yes ☐ No

If yes, assuming the patient were trying to work full-time, please estimate, on the average, how many days per month the 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

25. Would the patient's disability or impairment prevent him or her from traveling alone? ☐ Yes ☐ No
Why? _____

26. 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 the patient's ability to work at a regular job on a sustained basis.

_____

_____ _____
Signature Date

_____
Name, Title and Medical Specialty