

VISION IMPAIRMENT 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, laboratory and test results as appropriate.*

Please answer the following questions concerning your patient's impairments.

1. Frequency and length of contact: _____

2. Diagnoses: _____

3. Prognosis: _____

4. Visual acuity after best correction right eye: _____

5. Visual acuity after best correction left eye: _____

6. Describe any contraction of peripheral visual fields:

7. Describe your patient's vision *symptoms*:

“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.

8. As a result of your patient's impairments, estimate your patient's vision limitations if your patient were placed in a ***competitive work situation***.

a. How often can your patient perform work activities involving the following?

	Never	Rarely	Occasionally	Frequently	Constantly
Near Acuity	<input type="checkbox"/>				
Far Acuity	<input type="checkbox"/>				
Depth Perception	<input type="checkbox"/>				
Accommodation	<input type="checkbox"/>				
Color Vision	<input type="checkbox"/>				
Field of Vision	<input type="checkbox"/>				

b. Is your patient capable of avoiding ordinary hazards in the workplace, such as boxes on the floor, doors ajar, approaching people or vehicles? Yes No

c.. Does your patient have any difficulty walking up or down stairs? Yes No

d. Can your patient work with small objects such as those involved in doing sedentary work? Yes No

e. Can your patient work with large objects? Yes No

9. Please identify any exertional limitations; and please explain the relationship of these limitations to your patient’s vision:

a. 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"/>

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

	Never	Rarely	Occasionally	Frequently
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"/>

c. Please explain the medical basis for the above limitations and whether they are related to your patient’s eye problem:

10. Will your patient sometimes need to take unscheduled breaks during an 8-hour 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) please explain why such breaks are necessary:

11. 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

12. Please describe any other limitations 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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