

## ***LUPUS (SLE) 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. Does your patient fulfill the diagnostic criteria for systemic lupus erythematosus (SLE) identified by the American College of Rheumatology (namely, ***exhibit at any time at least four of the first eleven signs or symptoms listed in question #4 below***)?

Yes       No

3. Other diagnoses: \_\_\_\_\_

4. Identify any clinical findings, laboratory and test results, symptoms and positive objective signs of your patient's impairment (or adverse effects of treatments):

a.  Malar rash (over the cheeks)

c.  Photosensitivity

b.  Discoid rash

d.  Oral ulcers

e.  Non-erosive arthritis involving pain in two or more peripheral joints. ***Note if affected joints also exhibit:***

Identify affected joints:

tenderness

swelling

effusion

f.  Cardiopulmonary involvement shown by pleuritis or pericarditis

g.  Renal involvement shown by a) persistent proteinuria shown by:

greater than 0.5 gm/day ***or***  3+ on test sticks ***or*** b)  cellular casts.

h.  Central nervous system involvement shown by seizures and/or psychosis (in absence of drugs or metabolic disturbances known to cause such effects)

i.  Hemolytic anemia ***or***  
leukopenia (white blood count below 4,000/mm<sup>3</sup>) ***or***  
lymphopenia (below 1,500 lymphocytes/mm<sup>3</sup>) ***or***  
thrombocytopenia (below 100,000 platelets/mm<sup>3</sup>)

j.  Anti-DNA ***or*** anti-Sm anti-body ***or*** positive finding of antiphospholipid antibodies based on 1) abnormal serum level of IgG or IgM anticardiolipin antibodies, 2) a positive test result for lupus anticoagulant using a standard method or 3) a false-positive serologic test for syphilis known to be positive for at least six months and confirmed by Treponema pallidum immobilization or fluorescent treponemal antibody absorption test.

k.  Positive test for ANA at any point in time (in absence of drugs known to cause abnormality)

l. Constitutional Symptoms

Severe fatigue

Fever

Involuntary weight loss

Malaise

m. List any other signs or symptoms: \_\_\_\_\_

---

5. Identify Major Organ or Body System Involvement *at least to a moderate degree*

**Respiratory**

**Renal** - Glomerulonephritis

Pleuritis

**Neurologic** - Seizures

Pneumonitis

**Mental**

**Cardiovascular**

Anxiety

Endocarditis

Fluctuating cognition – lupus fog

Myocarditis

Mood disorders

Pericarditis

Organic brain syndrome

Vasculitis

Psychosis

**Hematologic**

**Other immune system disorder**

Anemia

Inflammatory arthritis

Leukopenia

Sjögren's syndrome

Thrombocytopenia

**Skin**

6. Functional Limitations

Limitation of activities of daily living

None or Mild

Moderate

Marked

Limitation in maintaining social functioning

None or Mild

Moderate

Marked

Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence or pace

None or Mild

Moderate

Marked

7. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations?  Yes  No

8. Identify prescribed medications and treatments and the side effects of any medication (particularly of steroids, if applicable) that may have implications for working, e.g., dizziness, drowsiness, stomach upset, cataracts, liver damage, etc.:

9. Prognosis: \_\_\_\_\_



*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.*

h. How many pounds can your patient lift and carry in a competitive work situation?

	<b>Never</b>	<b>Rarely</b>	<b>Occasionally</b>	<b>Frequently</b>
Less than 10 lbs.	<input type="checkbox"/>	<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"/>

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

	<b>Never</b>	<b>Rarely</b>	<b>Occasionally</b>	<b>Frequently</b>
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"/>

j. If your patient has significant limitations with reaching, handling or fingering, please indicate the percentage of time during an 8-hour working day that your patient can use hands/fingers/arms for the following activities

	<b>HANDS: Grasp, Turn Twist Objects</b>	<b>FINGERS: Fine Manipulations</b>	<b>ARMS: Reaching In Front of Body</b>	<b>ARMS: Reaching Overhead</b>
<b>Right:</b>	%	%	%	%
<b>Left:</b>	%	%	%	%

k. State the degree to which your patient should avoid the following:

<b>ENVIRONMENTAL RESTRICTIONS</b>	<b>AVOID</b>			
	<b>NO RESTRICTIONS</b>	<b>AVOID CONCENTRATED EXPOSURE</b>	<b>EVEN MODERATE EXPOSURE</b>	<b>AVOID ALL EXPOSURE</b>
Extreme cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extreme heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High humidity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wetness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cigarette smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perfumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soldering fluxes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Solvents/cleaners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fumes, odors, gases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dust	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemicals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
List other irritants:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

