CYSTIC FIBROSIS
TREATING PHYSICIAN
DATA SHEET

Short form

FOR REPRESENTATIVE USE ONLY

REPRESENTATIVE'S NAME AND ADDRESS

REPRESENTATIVE'S TELEPHONE

REPRESENTATIVE'S EMAIL

PHYSICIAN'S NAME AND ADDRESS

PHYSICIAN'S TELEPHONE

PHYSICIAN'S EMAIL

PATIENT'S NAME AND ADDRESS

PATIENT'S TELEPHONE

PATIENT'S EMAIL

PATIENT'S SSN

TYPE OF CLAIM:

Title 2 ☐ DIB/DWB ☐ CDB
Title 16 ☐ DI ☐ DC

LEVEL OF ADJUDICATION:

Initial DDS ☐ Recon DDS ☐
Initial CDR ☐ Hearing Officer ☐
Administrative Law Judge ☐ Appeals Council ☐
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:

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

Note 2: This document only concerns cystic fibrosis. Other impairments and limitations resulting from a combination of impairments should be considered separately.

Note 3: 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.

I. Please also complete Form 3.02. The information needed on this form is important, but only supplemental to Form 3.02.

II. What is the patient's height and weight?

III. Have there been episodes of bronchitis, pneumonia, hemoptysis (more than blood-streaked), or respiratory failure requiring physician intervention in the past year?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please answer the following questions.

A. Does the person currently smoke?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, have you prescribed smoking cessation?

☐ **Yes** ☐ **No** ☐ **Unknown**

B. Please specify the following for the **past year**:

Total number of treatments, including ER:

Total number of intensive inpatient treatments **lasting over 24 hours**:

Number of inpatient treatments for bronchitis:

Number of inpatient treatments for pneumonia:

Number of inpatient treatments hemoptysis:

Nature of other intensive inpatient treatments required specifically for cystic fibrosis:

C. Has the patient missed prescribed medication doses?

☐ **Yes** ☐ **No** ☐ **Unknown**

If so, what and why?

IV. Does the patient have persistent pulmonary infection?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please provide the following information.

A. Is there superimposed, recurrent, and increased bacterial infection?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please specify organism.

B. Have superimposed, recurrent, symptomatic episodes of bacterial infection occurred at least once every 6 months? (These could include episodes in **Section III** above.)

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes,** was intravenous or nebulized antimicrobial therapy given?

☐ **Yes** ☐ **No** ☐ **Unknown**

V. If the patient is a child in which pulmonary function testing cannot be done to determine the FEV1, are any of the following are true.

A. History of dyspnea on exertion or accumulation of secretions as manifested by repetitive coughing or cyanosis.

☐ **Yes** ☐ **No** ☐ **Unknown**

B. Persistent bilateral rales and rhonchi or substantial reduction in breath sounds related to mucous plugging of the trachea or bronchi.

☐ **Yes** ☐ **No** ☐ **Unknown**

C. Appropriate medically acceptable imaging evidence of extensive disease, such as thickening of the proximal bronchial airways or persistence of bilateral peribronchial infiltrates.

☐ **Yes** ☐ **No** ☐ **Unknown**

VI. What is the sweat chloride?

VII. Has genetic characterization of the patient's cystic fibrosis been done?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please describe the results or attach report.

VIII. Other comments

IX. Complete Form 3.02 for other treatment, functional severity, or other issues.

_____
Physician's Name (print or type)

_____
Physician's Signature (no name stamps)

_____
Date