CHRONIC PULMONARY INSUFFICIENCY
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 chronic pulmonary insufficiency. 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.

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Form 3.02S (2006)

“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.

“CAT” means computerized axial tomography.

“MRI” means magnetic resonance imaging.

“FEV1” means forced expiratory volume at one second.

“FVC” means forced vital capacity.

“ABGS” means arterial blood gas study.

“RA” means room air.

“FIO_2” means fraction of inspired oxygen (0.21 for room air).

“PaO_2” means arterial oxygen pressure.

“pH” means log of hydrogen ion concentration.

“$PaCO_2$” means arterial carbon dioxide concentration.

“$HC0_3$” means bicarbonate ion concentration.

“SaO_2” means arterial oxygen saturation.

“SpO_2” means oxygen saturation by pulse oximetry.

“DLCO” means carbon monoxide diffusing capacity.

I. Please provide the date of diagnosis of chronic pulmonary insufficiency.

Date of diagnosis:

Is the patient’s pulmonary condition ☐ Acute ☐ Chronic

II. What is the diagnosis?

III. Please specify the clinical abnormalities present

Have height and weight been measured? ☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please provide the numbers (do not use patient-provided numbers).

Height: (inches without shoes)

Weight: (lbs)

Prolonged expiration	☐ **Yes**	☐ **No**	☐ **Unknown**
Respiratory effort at rest	☐ **Yes**	☐ **No**	☐ **Unknown**
Retractions	☐ **Yes**	☐ **No**	☐ **Unknown**
Clubbing of fingers	☐ **Yes**	☐ **No**	☐ **Unknown**
Cyanosis (resting)	☐ **Yes**	☐ **No**	☐ **Unknown**
Cyanosis (exercise)	☐ **Yes**	☐ **No**	☐ **Unknown**
Increased A-P diameter of chest	☐ **Yes**	☐ **No**	☐ **Unknown**
Heart disease	☐ **Yes**	☐ **No**	☐ **Unknown**
Flaring of nostril in breathing (infants)	☐ **Yes**	☐ **No**	☐ **Unknown**

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Flattening of diaphragms (by chest imaging) ☐ **Yes** ☐ **No** ☐ **Unknown**

Lung hyperlucency (by chest imaging) ☐ **Yes** ☐ **No** ☐ **Unknown**

Wheezing ☐ **Yes** ☐ **No** ☐ **Unknown**

Hyper-resonance to percussion ☐ **Yes** ☐ **No** ☐ **Unknown**

Pulmonary cavitation (by chest imaging) ☐ **Yes** ☐ **No** ☐ **Unknown**

Scarring in lungs (by chest imaging) ☐ **Yes** ☐ **No** ☐ **Unknown**

Pursing of lips ☐ **Yes** ☐ **No** ☐ **Unknown**

Rales (crackling, fine, Velcro ☐) ☐ **Yes** ☐ **No** ☐ **Unknown**

Hemoptysis (more than blood-streaked) ☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, what is the frequency of hemoptysis and volume of blood?

Other clinical abnormalities:

IV. Pulmonary Function Studies

Does the patient smoke?

☐ **Yes** ☐ **No** ☐ **Unknown**

What are the hemoglobin and hematocrit?

A. Has spirometry been done?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please provide copies of tracings, as Social Security regulations prohibit favorable determinations of disability without tracings to independently review. If electronic spirometry was done, please include calibration.

Flow-volume loop ☐ Time-volume curves ☐ Tested with bronchodilators? ☐

Please provide the value and date of the patient's most current and highest FEV1:

Please provide the value and date of the patient's most current and highest FVC:

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B. Have resting ABGS been done?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please give the value and date of the patient's most current room air ABGS or attach lab report.

Testing done in absence of heart failure or acute respiratory illness?

☐ **Yes** ☐ **No** ☐ **Unknown**

Date:

FIO_2:

PaO_2 (PO_2):

pH:

$PaCO_2$(PCO_2):

HCO_3:

SaO_2 (not by pulse oximetry):

C. Has pulse oximetry been done?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please give the value and date of the patient's most current room air values or attach lab report.

Testing done in absence of heart failure or acute respiratory illness?

☐ **Yes** ☐ **No** ☐ **Unknown**

Date:

SpO_2:

D. Has DLCO been done?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please give the value and date of the patient's most current values or attach lab report.

Date:

DLCO: (ml CO/min/mm Hg)

Corrected for smoker?

☐ **Yes** ☐ **No** ☐ **Non-Smoker**

E. Have exercise ABGS been done?

☐ **Yes** ☐ **No** ☐ **Unknown**

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

V. Pulmonary Imaging and Procedures

Please specify which of the following have been done (please attach report if available)

Plain chest x-ray ☐ **Yes** ☐ **No** ☐ **Unknown**

Thoracic CAT scan ☐ **Yes** ☐ **No** ☐ **Unknown**

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Bronchoscopy	☐ **Yes**	☐ **No**	☐ **Unknown**
Thoracic MRI	☐ **Yes**	☐ **No**	☐ **Unknown**
Sputum collection and culture	☐ **Yes**	☐ **No**	☐ **Unknown**
Ventilation-Perfusion (VP) scan	☐ **Yes**	☐ **No**	☐ **Unknown**
Bronchial washings	☐ **Yes**	☐ **No**	☐ **Unknown**
Other (describe)	☐ **Yes**	☐ **No**	☐ **Unknown**

VI. Treatment

Please specify the last date you examined the patient. Date:

A. Medical therapy

1. Specify current medications and doses of drugs for respiratory disease.

2. Steroid, bronchodilator or diuretic dependency?
☐ **Yes** ☐ **No** ☐ **Unknown**

B. Surgical therapy

Has the patient had thoracic or pulmonary surgery?
☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, specify date and nature of surgery.

C. Is there growth impairment? (children)
☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please complete Form 100.02.

D. How many times has the patient been hospitalized in the past 6 months because of pulmonary disease?

E. Supplemental oxygen therapy

Patient uses physician-prescribed supplemental oxygen
☐ **Yes** ☐ **No** ☐ **Unknown**

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If **Yes**, please state frequency, flow rate, and effect on ABGS.

VII. *Current* Functional Limitations and Capacities

<u>Note</u>: The following questions apply only to patients at least 18 years of age.

In respect to the patient's pulmonary disease, please give your opinion in response to the following questions:

A. Is the patient able 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 without severe SOB or other symptoms?

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

☐ **Unknown**

☐ Less than 10 lbs.
☐ 10 lbs.
☐ 20 lbs.
☐ 50 lbs.
☐ 100 lbs.
☐ Other (lbs.)

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

☐ **Unknown**

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

D. Work environment temperature restrictions

1. Aside from exertional considerations such as lifting and carrying, does the patient have restrictions against exposure to extreme heat or cold?

☐ **Yes** ☐ **No** ☐ **Unknown**

Check the appropriate boxes:

"Concentrated exposure" means 1/3 to 2/3 of 8 hour workday.

"Moderate exposure" means very little up to 1/3 of 8 hour workday.

	Unlimited	Avoid Concentrated Exposure	Avoid Even Moderate Exposure	Avoid All Exposure
Extreme cold				
Extreme heat				
Dust or fumes				

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

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please state your opinion in regard to the maximum weight that can be lifted and carried:

Frequently:

Occasionally:

VIII. For children under age 18 only.

Does the child have significant limitations in age-appropriate activities?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, specify the age-appropriate limitations of which you are aware, citing specific developmental test results where possible.

IX. Additional Physician Comments (Also list other disorders of which you are aware.)

____

Physician’s Name (print or type)

____

Physician’s Signature (no name stamps)

____

Date

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