CHRONIC HEART FAILURE
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

LEVEL OF ADJUDICATION:

Initial DDS ☐ Recon DDS ☐

Initial CDR ☐ Hearing Officer ☐

Administrative Law Judge ☐ Appeals Council ☐

Federal District Court ☐ Federal Appeals Court ☐

TYPE OF CLAIM:

Title 2 ☐ DIB/DWB ☐ CDB

Title 16 ☐ DI ☐ DC

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 heart failure. 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.

"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.

"Current" means within the past 6 months.

I. Did you make the patient's initial diagnosis of heart failure?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please specify the date and briefly state the abnormalities resulting in a diagnosis of heart failure at your **initial** diagnosis.

Date:

II. Response to Treatment

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

A. Medical therapy

Specify current medications and doses of drugs for chronic heart failure.

B. Surgical therapy (including pacemaker, implanted defibrillator, coronary bypass, valve replacement, etc.)

Has the patient had cardiac surgery?

☐ **Yes** ☐ **No**

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

Did surgery relieve or improve the patient's heart failure?

☐ **Yes** ☐ **No** ☐ **Unknown**

C. Current Clinical Condition

1. What symptoms and/or signs specified in **Section I** above did the patient have on the most recent examination date given above?

2. What are the current blood pressure, pulse rate, and respiratory rate?

3. Does the patient have a current, *uncontrolled* cardiac arrhythmia?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, what is the type of arrhythmia?

III. Cardiac Imaging and Laboratory

If the following information is ***currently*** known:

A. On plain PA standing x-ray, what is the CT ratio?

B. If echocardiography, radionuclide imaging, magnetic resonance imaging, or cardiac catheterization have been done, please describe the abnormalities that still exist post-treatment.

C. Has the patient had ***current*** cardiac stress testing, following optimum treatment for heart failure?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please specify or attach report with same information:

- Date of test
- MET or other workload level attained
- Reason for stopping test
- Whether blood pressure response was normal
- EKG (ECG) abnormalities, including MET level of appearance, associated vital signs, and other relevant clinical abnormalities if any.
- If any imaging study (echocardiography, radionuclide scan) was done with exercise or pharmacologic stress testing. Briefly describe results.

D. Other **current** laboratory information relevant to chronic heart failure (e.g., electrolytes, natriuretic peptide)

IV. *Current* Functional Limitations

A. Please indicate the patient's approximate NYHA class currently (use combinations, if more appropriate, i.e., II-III for moderate limitation).

Class I	No limitation: ordinary physical exercise does not cause undue fatigue, dyspnea or palpitations.
Class II	Slight limitation of physical activity: comfortable at rest but ordinary activity results in fatigue, palpitations dyspnea or angina.
Class III	Marked limitation of physical activity: comfortable at rest but less than ordinary activity results in symptoms.
Class IV	Unable to carry out any physical activity without discomfort: symptoms of heart failure are present even at rest with increased discomfort with any physical activity.

Additional comments about cardiac functional limitations (specific examples, types of limiting symptoms, and task completion times are most helpful—for example, in your opinion, could the patient walk 1 block at a normal pace while carrying no weight? 2 blocks? Climb one or more flights of stairs?).

B. Does the patient have **current** angina?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please complete the separate chest pain Form 4.04CP.

C. Specific residual functional capacities and limitations

Note: The following questions apply only to patients at least 18 years of age. For younger children, please discuss any known limitations in age-appropriate activities in **Section V**.
In respect to the patient's cardiac impairment, please give your opinion in response to the following questions:

1. Does the patient have the strength and stamina 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?

2. 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.)

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

☐ **Unknown**

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

4. 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				

5. 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 under such conditions:

Frequently:

Occasionally:

6. Specific types of extremity exertion

Can the following activities be performed (from a cardiovascular standpoint)?

☐ **Unknown**

Pushing or pulling: ☐ never ☐ occasionally ☐ frequently

Climbing: ☐ never ☐ occasionally ☐ frequently

Overhead work: ☐ never ☐ occasionally ☐ frequently

V. 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.

VI. Additional Physician Comments

Physician's Name (print or type)

Physician's Signature (no name stamps)

Date