CHRONIC LIVER DISEASE
TREATING PHYSICIAN
DATA SHEET

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 ☐ FRO ☐

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 liver disease. 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.

I. Does the patient have chronic liver disease?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please specify the date and etiology of the initial diagnosis.

Date:

- Hepatitis A ☐ **Yes** ☐ **No** ☐ **Unknown**
- Hepatitis B ☐ **Yes** ☐ **No** ☐ **Unknown**
- Hepatitis C ☐ **Yes** ☐ **No** ☐ **Unknown**
- Hepatitis D ☐ **Yes** ☐ **No** ☐ **Unknown**
- Hepatitis E ☐ **Yes** ☐ **No** ☐ **Unknown**
- Hepatitis F ☐ **Yes** ☐ **No** ☐ **Unknown**
- Hepatitis G ☐ **Yes** ☐ **No** ☐ **Unknown**
- Chronic active hepatitis ☐ **Yes** ☐ **No** ☐ **Unknown**
- Alcoholic hepatitis ☐ **Yes** ☐ **No** ☐ **Unknown**
- Drugs ☐ **Yes** ☐ **No** ☐ **Unknown**
  Specify drug(s):
- Parasitic infection ☐ **Yes** ☐ **No** ☐ **Unknown**
  Specify parasite:
- Autoimmune hepatitis ☐ **Yes** ☐ **No** ☐ **Unknown**
  Specify disease:
- Bacterial infection ☐ **Yes** ☐ **No** ☐ **Unknown**
  Specify organism:
- Fungal infection ☐ **Yes** ☐ **No** ☐ **Unknown**
  Specify fungus:
- Protozoan infection ☐ **Yes** ☐ **No** ☐ **Unknown**
  Specify organism:
- Tumor (malignant—primary or metastatic) ☐ **Yes** ☐ **No** ☐ **Unknown**
  Specify diagnosis:

- Wilson's disease ☐ **Yes** ☐ **No** ☐ **Unknown**
- Porphyria ☐ **Yes** ☐ **No** ☐ **Unknown**
- Glycogen storage disease ☐ **Yes** ☐ **No** ☐ **Unknown**
  Specify diagnosis:

- Vascular disease ☐ **Yes** ☐ **No** ☐ **Unknown**
  Specify diagnosis:

- Cystic fibrosis ☐ **Yes** ☐ **No** ☐ **Unknown**
- Biliary cirrhosis ☐ **Yes** ☐ **No** ☐ **Unknown**
- Biliary atresia ☐ **Yes** ☐ **No** ☐ **Unknown**
- Toxic exposure ☐ **Yes** ☐ **No** ☐ **Unknown**
  Specify agent:

- Liver transplant ☐ **Yes** ☐ **No** ☐ **Unknown**
- Other (specify) ☐ **Yes** ☐ **No** ☐ **Unknown**

- Unknown ☐ **Yes** ☐ **No** ☐ **Unknown**

II. Does the patient have portal hypertension? ☐ **Yes** ☐ **No** ☐ **Unknown**
If **Yes**, please describe diagnostic results or attach report.

III. Does the patient have esophageal varices? ☐ **Yes** ☐ **No** ☐ **Unknown**
If **Yes**, please answer the following questions:

A. Were varices seen on endoscopy? ☐ **Yes** ☐ **No** ☐ **Unknown**

Were actively bleeding varices seen? ☐ **Yes** ☐ **No** ☐ **Unknown**

B. Were varices seen on other esophageal imaging? ☐ **Yes** ☐ **No** ☐ **Unknown**
What test?

C. Has the patient had variceal bleeding requiring both hospitalization and transfusion?
☐ **Yes** ☐ **No** ☐ **Unknown**

How many times has this happened?

Date of last bleeding:

Please specify the dates transfusions were requires and the amount (units) of each transfusion, or attach relevant medical records.

IV. Response to Treatment

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

A. Medical therapy

Specify current medications and doses of drugs.

B. Surgical therapy

1. Has the patient had shunt surgery for portal hypertension? ☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please specify date and type of shunt, including pre-op venous pressures or attach report.

Did shunt surgery relieve or improve portal hypertension and variceal bleeding?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please specify post-op venous pressures, or attach report.

2. Other surgery (Specify)

C. Treatment compliance?

Is the patient compliant with treatment? ☐ **Yes** ☐ **No** ☐ **Unknown**

D. Does the patient currently abuse alcohol or other drugs? ☐ **Yes** ☐ **No** ☐ **Unknown**

E. Current Clinical Condition

1. Is a special diet required? ☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please describe the diet, how long it takes to eat, and the patient's current height and weight.

Height (without shoes):

Weight (without shoes or heavy clothing):

2. Is the last measured total serum bilirubin normal? ☐ **Yes** ☐ **No** ☐ **Unknown**
   If **No**, what is the last measured total serum bilirubin and date?

   If the last bilirubin is 2.5 mg/dl or greater, how long has it been this high? (attach lab work)

3. Is the last measured serum albumin normal? ☐ **Yes** ☐ **No** ☐ **Unknown**
   If **No**, what is the last measured serum albumin and date?

   If the last serum albumin is 3.0 g/dl or less, how long has it been this low? (attach lab work)

4. Is there current ascites attributable to liver disease? ☐ **Yes** ☐ **No** ☐ **Unknown**
   If **Yes**, was the diagnosis made by paracentesis? ☐ **Yes** ☐ **No** ☐ **Unknown**

   How long has ascites been present?

   If hepatic ascites is present, has there been spontaneous bacterial peritonitis?
   ☐ **Yes** ☐ **No** ☐ **Unknown**

   If **Yes**, what was the diagnostic date and the absolute neutrophil count in the peritoneal fluid?

5. Is there current hydrothorax attributable to liver disease? ☐ **Yes** ☐ **No** ☐ **Unknown**
   If **Yes**, was the diagnosis made by thoracentesis? ☐ **Yes** ☐ **No** ☐ **Unknown**

   If not by thoracentesis, how was the diagnosis made?

   How long has hydrothorax been present?

6. Is there current hepatorenal syndrome attributable to liver disease? ☐ **Yes** ☐ **No** ☐ **Unknown**
   (or attach copies of relevant lab work, if more convenient)

   If **Yes**, what is the date and value of the most current serum creatinine?

   If **Yes**, what is the current 24-hour urine output?

Date:

If **Yes**, what is the current urine sodium concentration?

Date:

If **Yes**, what are the current serum electrolyte (Na, K, Cl) values?

Date:

If **Yes**, what other relevant lab work was done (e.g., serum or urine osmolality?)

Please cite dates and results.

7. Is there current hepatopulmonary syndrome attributable to liver disease?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, what is the date and value of the most current PaO_2 **on Room Air**?

Date:

If available, please include representative room air PaO_2 values for the past 6 months (or attach lab work if more convenient).

Is there documentation of intrapulmonary arteriovenous shunting? ☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, what were the diagnostic imaging tests done?

- ☐ Contrast-enhanced echocardiography
- ☐ Macroaggregated albumin lung perfusion scan
- ☐ Other (please specify below)

8. Is the last measured International Normalized Ratio (INR) normal?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **No**, please specify INR values and dates (for past 6 months if available)

9. Are the last measured hepatic enzymes normal? ☐ **Yes** ☐ **No** ☐ **Unknown**

If **No**, cite date and nature of abnormalities (or attach lab work).

10. Is there current hepatic encephalopathy? ☐ **Yes** ☐ **No** ☐ **Unknown**
If **Yes**, please answer the following questions, or attach relevant records.

Have mental abnormalities present on at least two evaluations at least 60 days apart during a consecutive 6-month period? ☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, which of the following have been observed?

☐ Confusion (Currently? ☐ **Yes** ☐ **No** ☐ **Unknown**)

☐ Delirium (Currently? ☐ **Yes** ☐ **No** ☐ **Unknown**)

☐ Stupor (Currently? ☐ **Yes** ☐ **No** ☐ **Unknown**)

☐ Coma (Currently? ☐ **Yes** ☐ **No** ☐ **Unknown**)

Other examples, of abnormal behavior, cognitive dysfunction, changes in mental status, or altered state of consciousness? — Discuss here.

11. Is there current anemia? ☐ **Yes** ☐ **No** ☐ **Unknown**
If **Yes**, what is the date and value of the most current hematocrit or hemoglobin?

12. In your opinion, is there currently end-stage liver disease? ☐ **Yes** ☐ **No** ☐ **Unknown**
Comments:

13. Is the patient post-liver transplantation? ☐ **Yes** ☐ **No** ☐ **Unknown**
If **Yes** and the patient is less than one year post-op, the claim is an automatic allowance under Social Security disability regulations with proof of transplantation. Completion of **Sections V** and **VI** this form are not necessary if less than one year post-op.

If **Yes**, and the patient is more than one year post-op, a complete physical examination is needed. If a complete current exam is available, attach a copy or use the space under **Section VII.** All transplant complications should be addressed, including any problems with non-hepatic organs. Additional forms may be needed, depending on the patient's current condition.

V. *Current* Functional Limitations - Specific residual functional capacities and limitations

If the patient is malnourished with significant weight loss, please also complete Form 5.08. In that event, it is not necessary to complete this section **V**. on this Form 5.05.

☐ Overall functional limitations are addressed on Form 5.08.

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 **VI**.

In respect to the patient's 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.)

VI. 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.

VII. Additional Physician Comments

Physician's Name (print or type)

Physician's Signature (no name stamps)

Date

VIII. Representative Notes