DIABETES MELLITUS
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 ☐ 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 diabetes mellitus. 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.
"Persistent" or **"chronic"** mean that the longitudinal clinical record shows that, with few exceptions, the required finding(s) has been at, or is expected to be present, for a continuous period of at least 12 months.

I. Does the patient have diabetes mellitus? ☐ **Yes** ☐ **No** ☐ **Unknown**

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

Date:

II. Please provide the following information. (Check all that apply.)

- **A. Juvenile diabetes mellitus** ☐
- **B. Adult onset diabetes mellitus** ☐
- **C. Insulin-dependent diabetes mellitus** ☐
- **D. Oral medication** ☐
- **E. Insulin pump** ☐
- **F. Inhaled insulin** ☐

III. Are there recurring episodes of acidosis? ☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please provide data from the most recent episodes, or attach records.

How many episodes of acidosis have occurred over the past 12 months?

Please provide values for serum glucose and arterial blood gases before and after treatment for each episode, and dates of hospitalizations.

IV. Are there recurring episodes of hypoglycemia? ☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please provide data from the most recent episodes, or attach records.

How many episodes of hypoglycemia have occurred over the past 12 months?

Please provide values for serum glucose before and after treatment for each episode, and whether hospitalization was required.

V. *Currently*, does the patient's diabetes have an effect on any body system sufficient to limit exertional or other function? ☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please describe the abnormalities with discussion of functional loss in regard to physical strength, gait, dexterous use of the hands, and vision. For a detailed report about multiple complications, it might be preferable to complete specific forms related to the type of impairment involved, e.g., Form 2.02 for visual loss and Form 6.02 for renal disease.

VI. Current Functional Limitations - Specific residual functional capacities and limitations

(Disregard questions if already addressed on a different form.)

☐ Functional limitations are already addressed on another form.

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 VII**.

1. Does the patient have the ability 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.)

VII. For children under age 18 only.

(Disregard questions if already addressed on a different form.)

☐ Functional limitations are already addressed on another form.

Does the child have growth impairment? ☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, complete Form 100.02.

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.

VIII. Additional Physician Comments

_____

Physician's Name (print or type)

_____

Physician's Signature (no name stamps)

_____

Date

IX. Representative Notes