

Medical Source Statement Form

Complete every section. Where a section does not apply, write 'not applicable' rather than leaving it blank.

Name: _____ Date completed: _____ dd / mm / yyyy
Date of birth: _____ dd / mm / yyyy Record / MRN number: _____
Report prepared by: _____ Date of report: _____ dd / mm / yyyy
Requested by: _____ Period covered: _____

REASON FOR THE REPORT

Why the report was requested and by whom.

BACKGROUND

Relevant history and what has happened so far.

FINDINGS

What was observed or measured, including patient identifiers and verification steps.

ASSESSMENT

Your interpretation of the findings.

RECOMMENDATIONS

What you are recommending, and why.

FOLLOW-UP

What happens next, including release destination and audit trail.

Signature and date
Name, role and registration number: _____