CHRONIC FATIGUE SYNDROME MEDICAL SOURCE STATEMENT

From: _____

Re: _____(Name of Patient)

_____(Social Security No.)

Please answer the following questions concerning your patient's impairments. *Attach relevant treatment notes, radiologist reports, laboratory and test results as appropriate.*

1. Frequency and length of contact: _____

2. Does your patient have Chronic Fatigue Syndrome? ☐ Yes ☐ No

3. Other diagnoses: _____

4. Prognosis: _____

5. Have your patient's impairments lasted or can they be expected to last at least twelve months? ☐ Yes ☐ No

6. Does your patient have unexplained persistent or relapsing chronic fatigue that is of new or definite onset (has not been lifelong), is not the result of ongoing exertion, and results in substantial reduction in previous levels of occupational, educational, social, or personal activities? ☐ Yes ☐ No

   If yes, please describe your patient's history of fatigue.

   _____

   _____

   _____

7. Have you been able to exclude any other impairments as a cause for your patient's fatigue such as HIV-AIDS, malignancy, parasitic disease (Lyme Disease), psychiatric disease, rheumatoid arthritis, drug or alcohol addiction or abuse, side effects of medications, etc.?
   ☐ Yes ☐ No

   If yes, please identify which impairments have been excluded and on what basis:

   _____

   _____

   _____

8. Does your patient have concurrent occurrence of four or more of the following symptoms, all of which must have persisted or recurred during six or more consecutive months of illness and must not have predated the fatigue? ☐ Yes ☐ No

If yes, please identify the symptoms:

- ☐ Self-reported impairment in short-term memory or concentration severe enough to cause substantial reduction in previous levels of occupational, educational, social or personal activities.
- ☐ Sore throat.
- ☐ Tender cervical or axillary lymph nodes.
- ☐ Muscle pain.
- ☐ Multiple joint pain without joint swelling or redness.
- ☐ Headaches of a new type, pattern or severity.
- ☐ Unrefreshing sleep.
- ☐ Post-exertional malaise lasting more than 24 hours.

9. Describe the treatment and response, including any side effects of medication that may have implications for working, e.g., drowsiness, dizziness, nausea, etc:

_____

_____

10. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations? ☐ Yes ☐ No

11. As a result of your patient's impairments, estimate your patient's functional limitations if your patient were placed in a ***competitive work situation:***

    a. How many city blocks can your patient walk without rest or severe pain? _____

    b. Please circle the hours and/or minutes that your patient can sit ***at one time***, e.g., before needing to get up, etc.

    Sit: 0 5 10 15 20 30 45 (Minutes) 1 2 More than 2 (Hours)

    c. Please circle the hours and/or minutes that your patient can stand ***at one time***, e.g., before needing to sit down, walk around, etc.

    Stand: 0 5 10 15 20 30 45 (Minutes) 1 2 More than 2 (Hours)

    d. Please indicate how long your patient can sit and stand/walk ***total in an 8- hour working day*** (with normal breaks):

Sit	**Stand/walk**	
☐	☐	less than 2 hours
☐	☐	about 2 hours
☐	☐	about 4 hours
☐	☐	at least 6 hours

    e. Does your patient need a job that permits shifting positions ***at will*** from sitting, standing or walking? ☐ Yes ☐ No

f. Will your patient sometimes need to take unscheduled breaks during a working day? ☐ Yes ☐ No

If yes, 1) how ***often*** do you think this will happen? _____

2) how ***long*** (on average) will your patient have to rest before returning to work? _____

3) on such a break, will your patient need to ☐ lie down or ☐ sit quietly?

g. While engaging in occasional standing/walking, must your patient use a cane or other assistive device? ☐ Yes ☐ No

For this and other questions on this form, "rarely" means 1% to 5% of an 8-hour working day; "occasionally" means 6% to 33% of an 8-hour working day; "frequently" means 34% to 66% of an 8-hour working day.

h. How many pounds can your patient lift and carry in a competitive work situation?

	Never	**Rarely**	**Occasionally**	**Frequently**
Less than 10 lbs.		☐	☐	☐
10 lbs.	☐	☐	☐	☐
20 lbs.	☐	☐	☐	☐
50 lbs.	☐	☐	☐	☐

i. How often can your patient perform the following activities?

	Never	**Rarely**	**Occasionally**	**Frequently**
Twist	☐	☐	☐	☐
Stoop (bend)	☐	☐	☐	☐
Crouch/ squat	☐	☐	☐	☐
Climb ladders	☐	☐	☐	☐
Climb stairs	☐	☐	☐	☐

j. Does your patient have significant limitations with reaching, handling or fingering? ☐ Yes ☐ No

If yes, please indicate the percentage of time during an 8-hour working day that your patient can use hands/fingers/arms for the following activities:

	HANDS: Grasp, Turn Twist Objects	**FINGERS: Fine Manipulations**	**ARMS: Reaching In Front of Body**	**ARMS: Reaching Overhead**
Right:	**%**	**%**	**%**	**%**
Left:	**%**	**%**	**%**	**%**

k. How much is your patient likely to be **"*off task*"**? That is, what percentage of a typical workday would your patient's symptoms likely be severe enough to interfere with ***attention and concentration*** needed to perform even simple work tasks?

☐ 0% ☐ 5% ☐ 10% ☐ 15% ☐ 20% ☐ 25% or more

l. To what degree can your patient tolerate work stress?

☐ Incapable of even "low stress" jobs ☐ Capable of low stress jobs
☐ Moderate stress is okay ☐ Capable of high stress work

Please explain the reasons for your conclusion: _____

m. Are your patient's impairments likely to produce "good days" and "bad days"?
☐ Yes ☐ No

If yes, assuming your patient was trying to work full time, please estimate, on the average, how often your patient is likely to be absent from work as a result of the impairments or treatment:

☐ Never ☐ About three days per month
☐ About one day per month ☐ About four days per month
☐ About two days per month ☐ More than four days per month

12. Please describe any other limitations (such as psychological limitations, limited vision, difficulty hearing, need to avoid temperature extremes, wetness, humidity, noise, dust, fumes, gases or hazards, etc.) that would affect your patient's ability to work at a regular job on a sustained basis:

_____

_____

_____

13. Are your patient's impairments (physical impairments plus any emotional impairments) ***reasonably consistent*** with the symptoms and functional limitations described in this evaluation? ☐ Yes ☐ No

If no, please explain: _____

14. What is the earliest date that the description of ***symptoms and limitation*** in this questionnaire applies? _____

_____ _____
Date *Signature*

Printed/Typed Name: _____

Address: _____

_____

_____

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