To: Re: ______________________________ (Name of Patient)

______________________________ (DOB)

Please answer the following questions concerning your patient's impairments. ***Attach all relevant treatment notes, radiologist reports, laboratory and test results that have not been provided previously to the Social Security Administration.***

1. Frequency and length of contact: ______________________________

2. Does your patient have Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS)? ___ Yes ___ No

3. Other diagnoses: ______________________________

   ____

   ____

4. Prognosis: ______________________________

5. Have the patient's impairments lasted or can they be expected to last at least 12 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 no**, identify which impairments you have not excluded and on what basis:

   ____

8. Does your patient have the *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**, 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.

   List any other ***medical signs*** that are consistent with medically acceptable clinical practice and are consistent with other evidence in the case record:

   ____

   ____

9. Indicate which, if any, of the following ***laboratory findings*** are present:

___ An elevated antibody titer to Epstein-Barr virus (EBV) capsid antigen or early antigen level
___ An abnormal magnetic resonance imaging (MRI) brain scan
___ An abnormal cardiopulmonary exercise test results (CPET @ Workwell)
___ Neurally mediated hypotension or postural orthostatic tachycardia syndrome as shown by tilt table testing or another clinically accepted form of testing.

List any other ***laboratory findings*** that are consistent with medically accepted clinical practice and are consistent with other evidence in the case record:

____

____

10. Indicate which, if any, of the following ***mental findings*** have been documented by mental status examination or psychological testing:

___ Short term memory deficit
___ Brain fog
___ Concentration limitations
___ Depression
___ Information processing limitations
___ Comprehension problems
___ Anxiety
___ Visual-spatial difficulties

Identify any other ***mental findings*** suggesting persistent Neurocognitive impairment:

____

11. Treatment and response, including list of medication(s) prescribed and their *side effects* on your patient: ____

____

12. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations?

___Yes ___ No If yes, please explain: ____

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. How often during a typical workday is your patient's experience of fatigue or other symptoms severe enough to interfere with **attention and concentration** needed to perform even simple work tasks?

___ Never ___ Rarely ___ Occasionally ___ Frequently ___ Constantly

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.

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

___Incapable of even "low stress" jobs
___Moderate stress is okay
___Capable of low stress jobs
___Capable of high stress work

Please explain the reasons for your conclusion: ______________________________________

16. As a result of your patient's impairments, estimate as best you can 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? ____________

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 the patient need a job which permits shifting positions *at will* from sitting, standing or walking?
___ Yes ___ No

f. Will your patient sometimes need to take unscheduled breaks during an 8 hour 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? ___________________

g. Does the disability or impairment require the patient to lie down during the day?

___ Yes ___ No If yes, please explain: ____

h. Would the patient's disability or impairment prevent him or her from traveling alone?

___ Yes ___ No If yes, please explain: ____

i. 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.	___	___	___	___

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

	Never	Rarely	Occasionally	Frequently
Twist	___	___	___	___
Stoop (bend)	___	___	___	___
Crouch	___	___	___	___
Climb ladders	___	___	___	___
Climb stairs	___	___	___	___

k. Does your patient have *significant limitations* in doing *repetitive* reaching, handling or fingering?
___Yes ___ No

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

	HANDS: Grasp, Turn, Twist Objects	**FINGERS**: Fine Manipulations	**ARMS**: Reaching (incl. Overhead)
Right:	___%	___%	___%
Left:	___%	___%	___%

l. Are the patient's impairments likely to produce "good days" and "bad days"? ___Yes ___ No

If yes, please estimate, on the average, how many days per month your patient is likely to be absent from work as a result of the impairments or treatment:

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

17. Describe any other limitations (such as 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:

____

____

____

18. What is the **earliest date** the description of symptoms and limitations stated above applies? ________________

________________________________ ________________________
Physician's Signature ***Date form completed***

Printed/Typed Name: ____________________________________

Address: ____________________________________

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