

CHRONIC FATIGUE SYNDROME
MEDICAL SOURCE STATEMENT

From: _____
Re: _____ (Name of Patient)
_____ (Social Security No.)

Please answer the following questions concerning your patient's impairments.
Refer to 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. 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
6. Have your patient's chronic fatigue symptoms lasted, or can they be expected to last, at least twelve months?
 Yes No
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:

- | | |
|--|--|
| <input type="checkbox"/> Sore throat. | <input type="checkbox"/> Headaches of a new type, pattern or severity. |
| <input type="checkbox"/> Tender cervical or axillary lymph nodes. | <input type="checkbox"/> Unrefreshing sleep. |
| <input type="checkbox"/> Muscle pain. | <input type="checkbox"/> Post-exertional malaise lasting more than 24 hours. |
| <input type="checkbox"/> Multiple joint pain without joint swelling or redness. | |
| <input type="checkbox"/> 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. | |

9. How do these symptoms / impairments interfere with your patient's ability to work eight hours per day, five days per week? _____

10. Please describe any difficulty your patient has with:

a) walking or standing: _____

b) sitting for prolonged periods of time: _____

c) reaching, handling, or fingering: _____

11. If your patient requires unscheduled breaks during the workday to rest because of symptoms, how many times per day would you expect this to happen? _____

12. How often is your patient likely to be "*off task*" because symptoms interfere with attention and concentration? _____

13. How well can your patient tolerate work stress? _____

14. 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:

Date

Signature

Printed/Typed Name: _____

Address: _____

