SEIZURES MEDICAL SOURCE STATEMENT

From: ______________________________

Re: ______________________________ (Name of Patient)

______________________________ (Social Security No.)

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

1. Frequency and length of contact:____

2.. Does your patient have seizures? ☐ Yes ☐ No

Other diagnoses:____

3. If your patient has seizures:

A. What type of seizures does your patient have?

☐ Convulsive (grand mal or psychomotor)
☐ Nonconvulsive (petit mal, psychomotor or focal)

B. Is there loss of consciousness during seizure? ☐ Yes ☐ No

If no, is there alternation of awareness during seizure? ☐ Yes ☐ No

C. Does your patient always have a warning of an impending seizure? ☐ Yes ☐ No

If yes, how long is it between the warning and onset of the seizure? ______minutes

Can your patient always take safety precautions when a seizure is coming on? ☐ Yes ☐ No

D. What is the average frequency of seizures? _____ per week _____ per month

E. Do seizures occur at a particular time of the day? ☐ Yes ☐ No

If yes, explain when seizures occur:____________________________________

F. Please provide a detailed description of a typical seizure: ________________________

____

____

____

G. Identify ***symptoms or signs*** associated with your patient’s seizure disorder:

☐ Presence of aura ☐ Tongue bites or other injures
☐ Loss of sphincter control ☐ Loss of bladder control
☐ Other: ______________________________

H. Identify postictal phenomena:

☐ Confusion ☐ Muscle strain ☐ Exhaustion
☐ Paranoia ☐ Irritability ☐ Difficulties communicating
☐ Severe headaches ☐ Other: ___________________________________

How long after a seizure do these postictal phenomena last? ________________

I. Does your patient typically need to rest after a seizure? ☐ Yes ☐ No

If yes, for approximately how long:_________________

J. Describe the degree to which having a seizure interferes with your patient's daily activities following a seizure:

____

____

K. What sort of action must others take during and immediately after your patient's seizure?

☐ Put something soft under the head ☐ Remove glasses
☐ Clear the area of hard or sharp objects ☐ Loosen tight clothing
☐ After seizure, turn patient on side to allow saliva to drain from mouth
☐ Other: ____

4. Identify positive test results (e.g., EEG): ____

5. Can stress precipitate your patient’s seizures? ☐ Yes ☐ No

If yes, to what degree can your patient tolerate work stress?

☐ Incapable of even "low stress" work ☐ Capable of low stress work
☐ Capable of moderate stress - normal work ☐ Capable of high stress work

6. Can exertion precipitate your patient’s seizures? ☐ Yes ☐ No

If yes, if your patient was placed in a competitive job,

A. 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

For this question "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.

B. 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.	☐	☐	☐	☐

7. Type of medication and response:____

____

8. Is your patient compliant with taking medication? ☐ Yes ☐ No

9. Please identify any side effects of seizure medication:

☐ Dizziness ☐ Double vision
☐ Eye focusing problems ☐ Coordination disturbance
☐ Lethargy ☐ Lack of alertness
☐ Other: ____

10. If your patient's blood levels of anticonvulsant medication have recently been at less than therapeutic levels, please explain why there has been difficulty controlling blood levels.

____

____

____

11. Does your patient currently abuse alcohol or street drugs? ☐ Yes ☐ No

A. If no, to the best of your knowledge, when was the last time your patient abused alcohol or street drugs? ☐ Never ☐ ______________________

B. If yes, if you were to assume your patient was able to maintain complete sobriety, would your patient continue to exhibit the symptoms and limitation described in this questionnaire? ☐ Yes ☐ No

Please explain: ____

12. Does your patient have any associated mental problems? ☐ Yes ☐ No

If yes, please check those that apply:

☐ Depression ☐ Short attention span
☐ Irritability ☐ Memory problems
☐ Social isolation ☐ Behavior extremes
☐ Poor self-esteem ☐ Other: ______________________________

13. In addition to time away from work for seizures and postictal phenomena, will your patient otherwise 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? ____________________

3) what are the reasons for such breaks? ____________________

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

If yes, assuming your patient was attempting to work full time, 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 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

15. Please describe any other limitations (such as limitations in the ability to bend, stoop, limitations in using arms, hands, fingers, 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: ______________________________

____

____

7-57
8/09
§239.1