

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 injuries
- 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	
<input type="checkbox"/>	<input type="checkbox"/>	less than 2 hours
<input type="checkbox"/>	<input type="checkbox"/>	about 2 hours
<input type="checkbox"/>	<input type="checkbox"/>	about 4 hours
<input type="checkbox"/>	<input type="checkbox"/>	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.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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:

- | | |
|--|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Eye focusing problems | <input type="checkbox"/> Coordination disturbance |
| <input type="checkbox"/> Lethargy | <input type="checkbox"/> Lack of alertness |
| <input type="checkbox"/> 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:

- | | |
|---|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Short attention span |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Memory problems |
| <input type="checkbox"/> Social isolation | <input type="checkbox"/> Behavior extremes |
| <input type="checkbox"/> Poor self-esteem | <input type="checkbox"/> 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:

- | | |
|---|--|
| <input type="checkbox"/> Never | <input type="checkbox"/> About three days per month |
| <input type="checkbox"/> About one day per month | <input type="checkbox"/> About four days per month |
| <input type="checkbox"/> About two days per month | <input type="checkbox"/> 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: _____

