LINER LEGAL
DISABILITY LAWYERS

CHRONIC FATIGUE SYNDROME / MYALGIC ENCEPHALOMYELITIS (ME) MEDICAL SOURCE STATEMENT

Patient Name:_____ Date:_____

Provider Name / Specialty:_____

SECTION 1 — DIAGNOSIS, DURATION, AND CORE CLINICAL FEATURES

Chronic Fatigue Syndrome / ME diagnosed by a medical provider? ☐ Yes ☐ No

Date of diagnosis: _____

Condition expected to last ≥ 12 months? ☐ Yes ☐ No

Core clinical features documented longitudinally (check all that apply):

☐ Persistent or relapsing fatigue not alleviated by rest
☐ Post-exertional malaise (worsening of symptoms after physical or mental exertion)
☐ Unrefreshing or non-restorative sleep
☐ Cognitive dysfunction ("brain fog")
☐ Orthostatic intolerance

SECTION 2 — POST EXERTIONAL VARIABILITY AND FUNCTIONAL DECLINE

How often does physical or mental exertion trigger symptom worsening or functional decline?

☐ Daily ☐ Several times per week ☐ Weekly ☐ Monthly ☐ Unpredictable

Typical duration of post exertional symptom worsening:

☐ < 24 hours ☐ 1–2 days ☐ 3–5 days ☐ 6+ days

During periods of symptom worsening, the patient is unable to reliably (check all that apply):

☐ Sustain attention or pace
☐ Perform even light tasks
☐ Remain upright without rest
☐ Leave home

SECTION 3 — PHYSICAL TOLERANCE (SITTING, STANDING, WALKING)

ACTIVITY	0	1	2	3	4	5	6+
SITTING	☐	☐	☐	☐	☐	☐	☐
STANDING	☐	☐	☐	☐	☐	☐	☐
WALKING	☐	☐	☐	☐	☐	☐	☐

Needs to alternate positions at will? ☐ Yes ☐ No

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SECTION 4 — RELIABILITY, PACE, AND ABSENCES

Ability to sustain attention, concentration, or pace during a typical workday:

☐ Limited to brief periods only
☐ Moderately limited
☐ Unable to sustain attention or pace for competitive work

Expected time away from the work task due to cognitive fatigue, symptom fluctuation, or recovery needs:

☐ 0% ☐ 10% ☐ 15% ☐ 20%+

Likely absences per month due to symptom flares, post-exertional decline, or recovery needs:

☐ None ☐ 1 ☐ 2 ☐ 3+ ☐ Unable to sustain full-time attendance

SECTION 5 — ORTHOSTATIC AND POSITIONAL LIMITATIONS (IF PRESENT)

Orthostatic symptoms when upright (check all that apply):

☐ Dizziness ☐ Palpitations ☐ Tachycardia ☐ Visual changes ☐ Near-syncope

Requires unexpected sitting or recumbence during the day? ☐ Yes ☐ No
Need to elevate legs during the day? ☐ Yes ☐ No

If yes: elevation height _____ Approximate % of the workday: _____ %

SECTION 6 — CONSISTENCY

Do the limitations described above reflect what you have consistently observed and documented over time, including longitudinal treatment records?

☐ Yes ☐ No ☐ Partially (explain): _____

Provider Signature: _____ Date: _____
Address / Phone: _____