

From: _____
(Doctor/Practice Name)

Re: _____
(Name of Patient)

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

1. Frequency and length of contact: _____

2. Diagnosis:

- Mastocytosis (all variants/types) Mast Cell Activation Syndrome (MCAS)
 Hereditary alpha Trypsinemia (HaT)

3. Which of the following symptoms are present in your patient:

- | | |
|---|--|
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Nausea and vomiting, abdominal pain |
| <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Syncope |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Overwhelming exhaustion/fatigue |
| <input type="checkbox"/> Brain fog/neurocognitive dysfunction | <input type="checkbox"/> Itching, +/- rash, hives |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Bone pain | <input type="checkbox"/> Anaphylaxis |
| <input type="checkbox"/> Angioedema (swelling) | <input type="checkbox"/> Wheezing/shortness of breath |
| <input type="checkbox"/> Throat swelling | <input type="checkbox"/> Low blood pressure/blood pressure instability |
| <input type="checkbox"/> Rapid heart rate (tachycardia) | |

4. If your patient has pain, characterize the nature, location, frequency, triggers, and severity of your patient's pain:

5. Identify the clinical findings and testing performed:

6. Describe the treatment and response including any side effects of medication that may have implications for working (e.g., drowsiness, dizziness, nausea, etc):

7. As a result of your patient's impairments, estimate your patient's functional limitations if your patient were placed in a **competitive work situation**.

a. Will your patient sometimes need to take unscheduled breaks during a 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 symptoms cause a need for breaks? _____

b. How much is your patient likely to be "**off task**"? That is, what percentage of a typical workday would your patient's symptoms likely be severe enough to interfere with **attention and concentration** needed to perform even simple work tasks?

0% 5% 10% 15% 20% 25% or more

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

If yes, assuming your patient was trying 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 |

8. 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 Name

_____ Address

_____ Address