THE MAST CELL DISEASE SOCIETY, INC.

***MAST CELL DISEASE MEDICAL SOURCE STATEMENT***

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 Tryptasemia (HaT)

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

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

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:

_____

_____

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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:

   ☐ Never
   ☐ About one day per month
   ☐ About two days per month
   ☐ About three days per month
   ☐ About four days per month
   ☐ 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/Typed Name:* _____

*Address:* _____

_____