Massachusetts ME/CFS & FM ASSOCIATION

EDUCATION, SUPPORT & ADVOCACY SINCE 1985

HEALTH CARE PROVIDER INFORMATION QUESTIONNAIRE

The Massachusetts ME/CFS & FM Association provides physician and other health care provider referrals to patients and their families. By filling out this questionnaire (please print), you will help us make needed referrals to other patients. If you can provide information on more than one provider, please fill out a separate form for each.

Please return this form(s) to: Mass ME/CFS & FM Assoc., P.O. Box 690305, Quincy, MA 02269.

The following information will enable us to contact you should we have any questions about the information you provide. Your personal information will be held in strictest confidence.

Your Name: _____

Address:_____

Phone #:_____

Email:_____

Tell us about the provider. Please fill in as much of the following information as you can.

Provider's First Name:_____ Last name:_____

Title: ☐MD ☐ PhD ☐ DO ☐Other

_____ _____

Address #1: (Office, HMO, etc.) Address #2: (Office, Hospital, etc.)

_____ _____

City State Zip code City State Zip code

_____ _____

Phone: ( ) ext. Phone ( ) ext.

#1_____ #2_____

Physician's medical specialty and secondary specialty (primary care, infectious disease, rheumatology, neurology, pain, sleep, psychiatry, etc.)

#1_____ #2 _____

Non-physician specialty (nurse practitioner, physical therapist, psychologist, naturopath, social worker, acupuncturist, etc.)

HEALTH CARE PROVIDER INFORMATION QUESTIONNAIRE

Tell us about your experience with this provider.

Today's date_____

Are you a ☐Patient ☐Family member ☐other (please explain) _____

How long have you been ill? _____

Are you currently under the care of this provider? ☐ Yes ☐No

If yes, how long have you seen this provider? ☐Under 6 months ☐6-24 months ☐Over 2 years

If a former patient, when did you stop seeing this provider? _____.

How long did you see this provider? ☐Under 6 months ☐6-24 months ☐Over 2 years

What illness(es) were you seeking treatment for?

☐CFIDS ☐ Fibromyalgia ☐Other, please explain _____

What is/was the provider's role in your treatment? ☐Primary care ☐ Specialist ☐Consult

☐Other, please explain_____

Please rate your physician's knowledge of ME/CFS.

☐Knowledgeable/supportive ☐NOT knowledgeable but open-minded

☐Unsympathetic or hostile ☐Don't know

Please rate your physician's knowledge of Fibromyalgia.

☐Knowledgeable/supportive ☐NOT knowledgeable but open-minded

☐Unsympathetic or hostile ☐Don't know

This provider will diagnose and treat (if both, check each): ☐ME/CFS ☐FM

This provider will be helpful to patients in obtaining disability benefits ☐ Yes ☐No

What insurance did you use with this provider? _____
What other insurance does this provider accept (if you know) _____
_____

Medicare? ☐ Yes ☐No ☐Don't know Mass. Health? ☐ Yes ☐No ☐Don't know

Would you recommend this provider to others?

☐Recommend highly ☐Recommend ☐Not recommend ☐Urge others to avoid

HEALTH CARE PROVIDER INFORMATION QUESTIONNAIRE

Please tell us about the diagnosis and treatment methods used by this provider:
Diagnostic testing: Does the physician use specialized medical diagnostic tests, including anti-body testing, MRIs or other brain scans, tilt-table, etc. If the physician combines traditional and holistic medicine, what types of tests are performed?

Treatments provided:
What treatments does the physician/provider use? If holistic/complementary treatments are provided, which are used?

Your overall comments on the physician/provider in terms of diagnosis and treatment:

The following questions pertain only to mental health professionals:

Is this provider able to distinguish between a ME/CFS & FM diagnosis and mental/emotional impairments?

Does this provider perform neuropsychological testing? ☐ Yes ☐No

If so, does the provider know how to properly evaluate the tests for ME/CFS? ☐ Yes ☐No

What type of approach does the provider use:

☐Individual counseling ☐Group counseling ☐Medication(s)

Does the provider understand the effects of medication on ME/CFS & FM?

Please give your overall opinion/evaluation of your experience with this provider:

Thank you.