Massachusetts CFIDS/ME & FM Association

Education, Support and Advocacy since 1985

HEALTH CARE PROVIDER INFORMATION QUESTIONNAIRE

The Mass. CFIDS/ME & 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. (You can obtain extra forms at our website, masscfids.org.)
Please return this form(s) to: the Mass. CFIDS Association, 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 by us.

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.)

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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 CFIDS.

☐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): ☐CFIDS ☐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

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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 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 CFIDS/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: CFIDS: ☐ 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 CFIDS and FM?

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

Thank-you