

**GUIDELINES FOR  
ASSESSING DISABILITY  
DUE TO  
PULMONARY DISORDERS**

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Issued by  
The Life Offices Association of S.A.  
and  
The S.A. Thoracic Society

Produced by SAMA Health and Medical Publishing  
Insert to SAMJ

## ASSESSING DISABILITY DUE TO PULMONARY DISORDERS.

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## 1. Introduction.

Pulmonary disorders along with low back pain, psychiatric disorders and cardiac disease are the main causes of disability.

It is clear that pulmonary disorders are an important cause of disability and are increasing annually in terms of days off work and the monetary value of claim payouts.

There are also a number of non-medical reasons that contribute to a disability claim:

- Employer anti selection.
- Employers often need to reduce staff numbers for various reasons and if this is done by way of a disability claim, it gives the impression of a more sympathetic approach by the employer and a better financial settlement for the employee. Workers can often be persuaded to lodge a claim based on some medical history despite the fact that they can work productively.

- Objectivity of medical reports.

The clinical reports insurance companies receive, seldom obtain objective opinions or findings and at best contain sketchy details of the patient's symptoms. This can lead to extended periods of absenteeism, the premature and incorrect labelling of patients as permanently disabled.

- Unfavourable working conditions.

It is well known that the number of disability claims can be increased with job dissatisfaction, unpleasant working conditions or menial job tasks. Recent legislation has addressed this problem by requiring employers to accommodate workers with impairments to enable them to continue working gainfully.

In an effort to address this problem, insurance companies are endeavouring to obtain opinions from specialists not involved in the patient's treatment and ask for an opinion on impairment only and not disability. Efforts are also being made to use objective methods to quantify impairment.

## **2. Defining guidelines for assessing disability due to pulmonary disorders.**

There are often differences of opinion between the clinician and the insurance medical advisor that may cause frustration and unhappiness on the part of all parties concerned. Concerns are often expressed about the complex nature of pulmonary disorders and the specialised investigations that need to be undertaken to evaluate claims

The Life Office's Association (LOA) initiated contact between the S.A. Thoracic Society (SATS) and its own medical and underwriting sub-committee with the view to addressing concerns that exist. This was done by means of a workshop to refine specific recommendations. The ultimate goal was to provide guidelines that could standardise the approach to claims based on a pulmonological problem. The format of the workshop was to address areas of differences by way of literature overviews and presentations with recommendations on each topic. After discussion, recommendations were drafted reflecting the decisions made by the participants.

The participants in the workshop were medical advisors from insurance companies i.e. Dr P. Coetzer (Sanlam), Dr. L. Boshoff (Momentum), Dr. I. Lockyer (Old Mutual) and Dr. D. Schorn (Liberty).

The pulmonologists representing SATS were Prof. J. Ker, Prof. E. Bateman, Prof. U. Lalloo, Prof. P. Bardin and Dr. M. Plit.

The guidelines for assessing disability were reviewed by the participants as well as members of the SATS Council. Alterations were accommodated and the final document was accepted and submitted for publication.

### **3. Impairment and Disability.**

For anyone dealing with claims on a medical basis, it is important to distinguish between “impairment” and “disability.”

#### **3.1 Impairment and Disability**

The World Health Organisation (WHO) defines impairment as “any loss or abnormality of psychological, physiological or anatomical structure or function.” (1) In essence, this is a medical concept describing an alteration in an individual’s health status. Impairment is assessed by medical means after a diagnosis has been made and appropriate treatment given. It is important to note which activities of daily living a person can perform or which are not possible. A report form to grade activities of daily living is given in the appendix.

It is also important to recognise that “normal” is not a fine point or absolute. Normality is often within a range, e.g. with vision or hearing and can vary with age, sex and other factors. Interpretations of normal that are too strict can result in over or underestimation of the degree of impairment.

#### **3.2 Disability**

The WHO defines disability as “any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being” (1)

The American Medical Association’s definition of disability as “an alteration in the individual’s capacity to meet personal, social or occupational demands or statutory or regulatory requirements because of an impairment.” (2)

The American Thoracic Society’s definitions are wider and less specific. (3) They do note that “impairment” is a purely medical concept and that disability is the total effect of the impairment on the person’s life.

Whereas impairment evaluation is a medical concept, disability assessment is a legal one. Disability represents the gap between what a person can do and what he or she wants or needs to do. (2) It is clear that an impairment per se is not necessarily a disability.

In assessing disability, the extent of a person's impairment has to be judged in the context of the job function, the definition of disability in the policy being considered and personal factors such as education, experience etc. These issues will be discussed in more detail in section 4.

It is therefore clear that no medical practitioner is in a position to express an opinion on disability. The practitioner will be fully informed regarding the medical condition and its effects of the activities of daily living, but he usually has no information on:

- The patient's working history, previous occupations, qualifications, experience etc.
- The relevant job description and
- The policy terms, conditions and definitions.

The doctor involved should therefore only supply the insurer or employer with detailed medical information and express an opinion on functional impairment due to the disease.

The examining doctor should inform the patient that the decision on disability will be made by the company concerned. This will be done by the company's doctors, legal advisors, claims assessors and other relevant persons.

#### **4. Assessing Disability.**

As has already been stated, disability assessment is a legal and not a medical concept that evolves as a decision made by a group of people.

The insurer takes the following into consideration when addressing disability claims:

- The claimant.
- Job description.
- Disability clause conditions.
- The medical impairment.

Factors regarding claimants that are considered included gender age qualifications, experience and previous occupational history.

Occupations can be classified into a number of categories, but are basically split into manual, supervisory or administrative functions. It becomes important to have a full description of the claimant's functional capacity and the effect that the impairment has on activities of daily living.

#### **4.1 Disability Clause Conditions.**

It is important to establish whether the necessary adaptations or accommodations have been undertaken at the workplace to enable the claimant to continue in the particular job.

Clearly, clause wordings will differ from one company to another, but in general, 3 different types of cover are available.

##### **4.1.1 Own Occupation.**

A claim will be considered when the claimant cannot perform his own specific job as was described and stated at the time of issue of the contract.

Continued exposure to a specific occupation may lead to progressive disease and the person should be removed from that environment.

This is the most expensive type of cover and is usually sold to professional people.

#### **4.1.2 Own Or Similar Occupation.**

A claim under the contract will be considered when the claimant is unable to perform his or her own occupation and is also incapable of performing a similar occupation that he or she may be expected to follow taking into account education, training and experience.

It is often this definition that leads to misunderstandings and unhappiness especially where a medical practitioner declares someone unfit to perform an occupation without having information regarding a clause condition.

#### **4.1.3 Any Occupation.**

This is an extremely wide definition and a claim will only be considered when the claimant is unable to perform even the most menial of tasks. This is the cheapest form of insurance and qualifications, experience, previous occupations and other issues are usually irrelevant.

### **4.2 Total and Permanent.**

#### **4.2.1 Permanence**

The concept of permanence is of crucial importance to assessments of disability.

A permanent impairment is one that has become static or stabilised during a period of time sufficient to allow optimal tissue repair and one that is unlikely to change in spite of further surgical or medical treatment. This concept is similar to the American Medical Association's expression of maximal medical improvement (2). As will be seen later, many policies require that a condition be permanent before disability benefits become payable.

Reasonable treatment will depend on the risks attached to such treatment, the degree of success that can be expected undergoing such treatment and what the average reasonable patient with a similar condition would be prepared to undergo.

The following forms of treatment are considered “reasonable” for chronic pulmonary disorders:

- **COPD.**

The Guidelines for COPD as suggested by the South African Thoracic Society should be followed. (4)

- a) The FEV<sub>1</sub> is measured and documented according to the method given in 5.1.
- b) The following bronchodilators are used:
  - (i) Ipratropium bromide MDI  
2 puffs 4 – 6 hourly.
  - Plus (ii) Beta – 2 agonist MDI.
  - Or (iii) Combination of (i) and (ii) in a single MDI.
  - Plus (iv) Oral slow-release theophylline  
(200-400mg twice daily or 400 – 800mg at night)
- c) A trial of steroids should be given, starting with 40mg Prednisolone for 14 days, after which the patient is re-evaluated to determine the degree of reversibility. Where there is no reversible airway obstruction , and where the patient has never previously received steroids, the steroid can be stopped without tapering. In cases with reversibility the steroid is tapered to the lowest maintenance dose.
- d) The FEV<sub>1</sub> is repeated and documented. An impairment may only be considered permanent if there is no objective improvement, i.e.the FEV<sub>1</sub>, improves less than 15% or 200ml. If there is greater improvement, a diagnosis of asthma should be considered.

- **Asthma.**

The guidelines for chronic asthma suggested by SATS should be we used as a basis for recommended treatment (5).

In assessing “optimal treatment” for asthma, the following aspects have to be considered:

- a) The diagnosis of asthma should be confirmed and should be well distinguished from COPD.

- b) The condition should be classified as mild intermittent or chronic persistent.
- c) Severity of chronic persistent asthma should be assessed as mild, moderate or severe.

The agents used in the treatments of asthma can be grouped as:

- a. Preventors - Including inhaled and oral corticosteroids.
- b. Controllers
  - Long acting B2 agonist inhaler.
  - Slow release theophylline.
  - Leukotrine receptor antagonists.
- c. Relievers - Short acting Beta2 agonist.
  - Anti-cholinergics.

The following guidelines would be considered to constitute reasonable treatment for all cases.

- a) Intermittent asthma:
  - combined low dose inhaled corticosteroids
  - and
  - long acting Beta2 agonist or slow release theophylline
  - or
  - inhaled corticosteroids 500-1000 ugm per day.
- b) Chronic persistent asthma:
  - short acting Beta2 agonist used as necessary, with
  - inhaled corticosteroids > 1000 ugm per day
  - and
  - oral corticosteroids and long acting Beta2 agonist
  - with or without
  - slow release theophylline
  - OR**
  - Inhaled corticosteroids > 1000 ugm per day, and

long acting Beta2 agonist  
with or without  
slow release theophylline

Treatment should follow a stepwise approach based on severity.

c) Leukotrine receptor antagonists should be used in combination with inhaled corticosteroids, but not necessarily in all cases, until such time that efficacy can be judged with long term clinical data.

#### **4.2.2 Total Disability.**

A person will only be considered to be totally disabled when he is unable to perform a substantial percentage of his occupation despite adequate treatment. Disorders that are treatable, e.g. hypertension or periodic e.g. epilepsy will in general not be considered to be total or permanent.

#### **4.3 Availability of Employment.**

Disability insurance only covers a person's ability to work and not the availability of alternative employment or the ability to commute to work. The unavailability of another job within a company or in the open labour market is therefore irrelevant in terms of disability insurance.

### **5. Assessing Respiratory Functional Impairment.**

The examining doctor will be expected to do a thorough and objective evaluation of the patient's condition and its effect on functional capacity and in all cases he should refrain from expressing an opinion on disability.

This evaluation should include:

- A detailed history of the patient's pulmonary condition, including the symptoms associated with respiratory dysfunction as well as a history of

tobacco use, usually given in pack-years of cigarette smoking and an occupational and environmental history of exposure to substances that could affect the lungs.

- A complete systemic respiratory examination of the patient. Other systemic conditions that may contribute to the patients respiratory problems should be described in the report.
- Basic special investigations to help assess the degree of pulmonary dysfunction.
- Completion of a medical report which will meet the minimum standards as will be described later. If the doctor finds a need for an evaluation by a different specialist or other therapist, this should be mentioned in the report for the company to consider and arrange.

### **5.1 Special Investigations.**

When an insurance company refers a patient for a second objective opinion, the basic medical examination and special investigations should already have been done to help establish a proper clinical diagnosis and the degree of respiratory dysfunction. The following investigations may need to be carried out in order to make a judgement on the degree of functional impairment.

- Chest X-Ray.  
The initial examination should include postero-anterior and lateral views of the chest taken in full inspiration. It should be noted that chest x-rays often correlate poorly with physiologic findings in diseases with air flow obstruction such as asthma and emphysema.
- Lung function testing.  
The quantitative basis on which an evaluation of the respiratory impairment rests is physiological testing of pulmonary function. Simple spirometry should be performed on equipment that has been calibrated according to acceptable standards. (6)  
It must be noted that respiratory impairment may not necessarily be related to lung function. This is true in cases of occupational asthma, sleep

disorders, bullous disease, recurrent pneumothorax, lung cancer or pneumoconiosis. (3)

At least 3 spirometric tracings should be taken during forced expiration with the results of the 2 best readings being within 5% of each other. The forced vital capacity (FVC) and forced expiratory volume in the first second (FEV<sub>1</sub>) should be measured. The range of normal values can be found in the "Guides To The Evaluation Of Permanent Impairment". (2)

If the FEV<sub>1</sub>/FVC ratio is below 0.7, the spirometry should be repeated after the patient has used an inhaled bronchodilator.

The FEV<sub>1</sub>/FVC ratio is helpful in the diagnosis of obstructive airways disease. The severity is judged on the basis of the absolute value of the FEV<sub>1</sub> or the percentage of predicted of the FEV<sub>1</sub>.

- Diffusing capacity of carbon monoxide (Dco).

A single breath Dco should be used for the evaluation of impairment in those conditions when the diffusing capacity may be diminished. Measurement is particularly important in patients who have dyspnoea with relatively normal spirometry.

It is important that the patient should not have smoked for at least 8 hours before the test as carbon monoxide reduces the saturation of haemoglobin and causes a decrease in the Dco.

- Measured exercise capacity (VO<sub>2</sub>)

This may be undertaken under certain circumstances and often helps differentiate between pulmonary and cardiac conditions. Generally, exercise capacity measurement should not be undertaken on patients with normal pulmonary function tests or those with severe impairments, as the additional information will not be useful in assessing the ability to carry out daily activities. Exercise capacity may also be useful to exclude malingering.

- Arterial oxygenation (PO<sub>2</sub>)

This is rarely undertaken because of its invasive nature and because other factors may affect the arterial PO<sub>2</sub>.

## 5.2 Evaluating Permanent Pulmonary Impairment.

It has been agreed to use the criteria as defined in the American Medical Association's "Guides To The Evaluation Of Permanent Impairment" as presented in the following table. (2)

	<b>Class 1:</b> 0% no impairment of the whole person	<b>Class 2:</b> 10-25%, mild impairment of the whole person	<b>Class 3:</b> 26-50%, moderate impairment of the whole person	<b>Class 4:</b> 51-100%, severe impairment of the whole person
FVC	FVC>80% of predicted;	FVC between 60% and 79% of predicted;	FVC between 51% and 59% of predicted;	FVC<50% of predicted;
FEV1	and FEV1>80% of predicted;	or FEV1 between 60% and 79% of predicted;	or FEV1 between 41% and 59% of predicted;	or FEV1<40% of predicted;
FEV1/FVC (%)	and FEV1/FVC>70%			
Dco	and Dco>70% of predicted;	or Dco between 60% and 69% of predicted;	or Dco between 41% and 59% of predicted;	or Dco <40% of predicted;
	<b>or</b>	<b>or</b>	<b>or</b>	<b>or</b>
VO2 Max	>25mL/(kg.min) or >7.1 METS	Between 20 and 25mL/(kg.min) or 5.7-7.1 METS	Between 15 and 20mL/(kg.min) or 4.3-5.7 METS	<15mL/(kg.min) or <1.05L/min, or <4.3 METS

Asthma may present particular problems in assessing impairment due to its variable nature. Lung function tests may be normal between attacks. It may be necessary to do repeated tests over a period of time, and take the frequency of attacks into consideration. Where occupational exposure is thought to cause the impairment tests should be performed before and after work on at least 3 occasions. Careful documentation is necessary and referral to an asthma expert may be indicated.

### **5.3 Correlation Of Functional Impairment With Ability To Perform Tasks.**

It is the responsibility of the company to correlate this information, and not the examiner, who should refrain from giving an opinion.

It is clearly difficult to give precise guidelines or statistical correlations between results of measured tests and an individual's ability to function. There are also many other factors that may contribute to a person's functional impairment. The following are general guidelines that may help to assess a person's ability to function.

- In general, the FEV<sub>1</sub> correlates better with exercise capacity in persons with obstructive lung disease than the arterial PO<sub>2</sub>. In broad terms, persons with an FEV<sub>1</sub> greater than 60% of predicted are able to work whereas those with an FEV<sub>1</sub> of less than 45% are generally unable to work. Most people with an FEV<sub>1</sub> greater than 2 litres are able to work.
- Exercise capacity is measured by the uptake of oxygen (VO<sub>2</sub>) in mL(kg.min) or in METS. Exercise VO<sub>2</sub> determination can be undertaken on individual's who have mild or moderate (class 2 or 3) impairments. Those individuals with a VO<sub>2</sub> of 25mL(kg.min) can perform most jobs. With a VO<sub>2</sub> between 15 and 24 mL(kg.min) most sedentary and some light manual work can be undertaken whereas with a measurement of less than 15mL(kg.min) very few, if any tasks can be undertaken. In general, a person can sustain a work level of 40% of measured maximum VO<sub>2</sub> for an 8 hour period. The following table shows a relationship between work capacity and oxygen consumption.

<b>Work intensity for 70kg person</b>	<b>Oxygen consumption</b>	<b>Excess energy expenditure</b>
Light work	7mL/kg <0.5L/min	<2 METS
Moderate work	8-15mL/kg 0.6-1.0 /min	2-4 METS
Heavy work	16-20mL/kg 1.1-1.5 /min	5-6 METS
Very heavy work	21-30mL/kg 1.6-2.0 /min	7-8 METS
Arduous work	>30mL/kg >2.0L/min	>8 METS

- Arterial PO<sub>2</sub> of less than 55 mm Hg is strong evidence of a severe impairment.
- A 6 minute walk test may be used and the number of exacerbations per year should be noted

#### **5.4 Content Of The Clinical Report.**

The report has to be sufficiently detailed to provide adequate data to enable a third party to make an informed decision on a patient whom he or she has not examined clinically. The following data needs to be included as a basic framework for a report.

##### 1. Identification.

- Name
- Identity number
- Age
- Sex
- Date of birth
- Contract number
- Employer
- Occupational history

2. Detailed history and clinical findings.
3. Diagnosis.
4. Severity of the illness.
5. Treatment.
  - Dosage and types of medication.
  - Duration.
  - Possible surgical procedures.
  - Hospital admissions.
  - Other i.e. physiotherapy, rehabilitation.
6. Response to treatment.
7. Complications or other illnesses.
8. Prognosis.
9. The influence of the illness on activities of daily living.
10. Results of special examinations including lung function testing etc.

It must again be emphasised that the examining doctor should limit his comments to the clinical condition and impairments and not comment on disability.

The independent medical examiner may at his own discretion wish to include the following disclaimer or variation thereon in his report.

“The opinions rendered in this case are the opinions of this evaluator. This evaluation has been conducted on the basis of the medical examination and documentation as provided, with the assumption that the material is true and correct. If more information becomes available at a later date, an additional service/report/reconsideration may be requested. Such information may or may not change the opinions rendered in this evaluation. This opinion is based on a clinical assessment, examination, and documentation. This opinion does not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.”

## **6. Protocol For Evaluating Potential Claims.**

The following principles should be adhered to maintain uniformity of claims evaluation.

### **6.1 The Treating General Practitioner or Pulmonologist.**

It is generally agreed that the treating doctor, either a general practitioner or pulmonologist should not be involved in assessing impairment on his patient. The doctor may have been involved with his patient and the family for many years and it is possible that the treating doctor will be subjectively involved in the illness.

A full report from the treating doctor will be obtained, but these reports will only be used to obtain a full history and cause of the illness. The insurance companies do not underestimate the value of the information obtained from the treating doctor.

The evaluating pulmonologist will act as an independent medical examiner to assess the functional impairment.

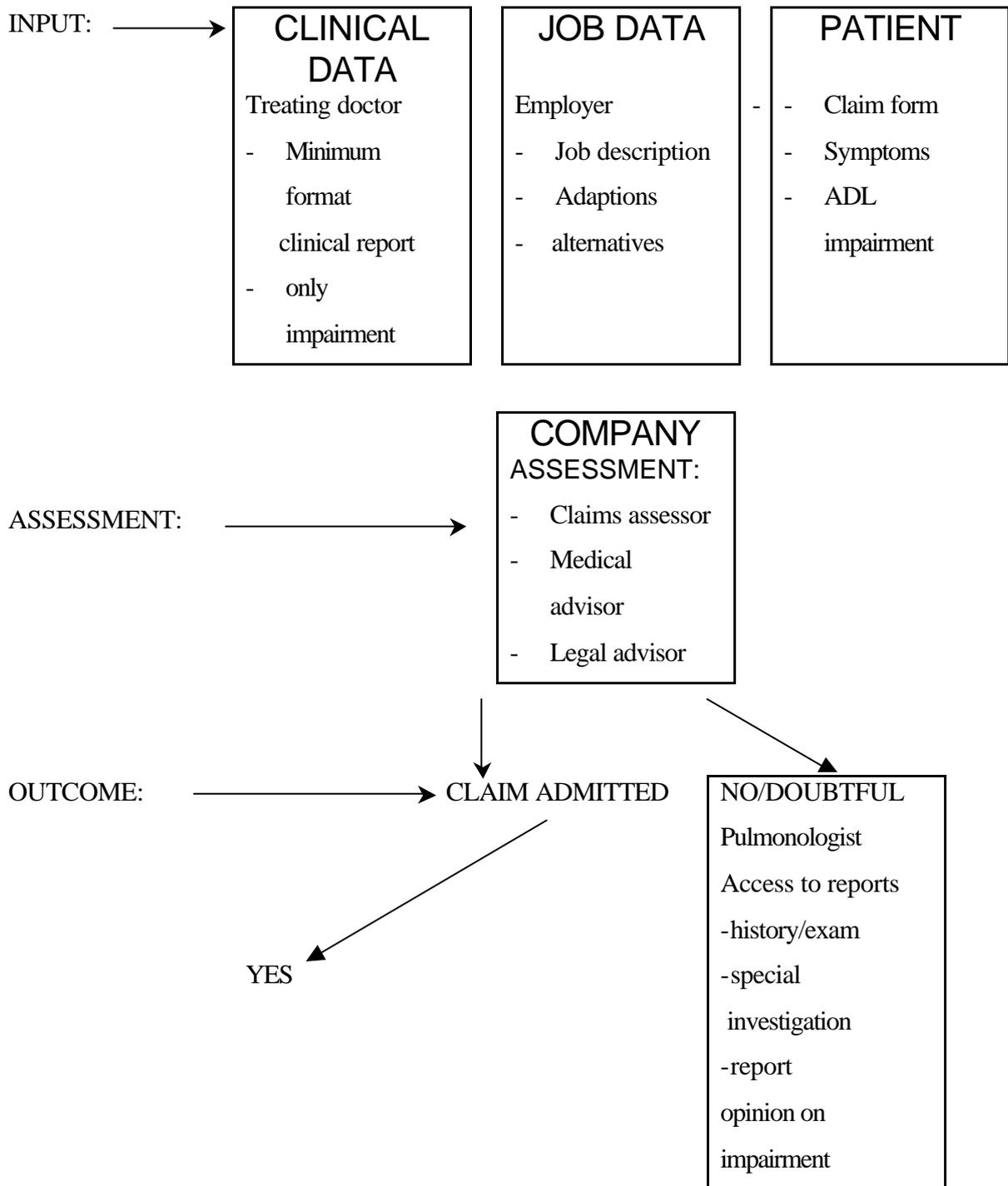
The independent examiner should inform the patient before the examination:

- That the report will only be used as background information.
- That he/she will not express an opinion on disability and will only provide clinical details on functional impairment.
- That the final decision of disability lies with the insurance company.

This process will relieve undue pressure on doctors by moving the process of making a final decision to the insurance company. This will hopefully result in more objective reports.

## 6.2 Flow Diagram

The following flow diagram summarises the approach for objective assessment of impairment due to pulmonary disease. All companies are urged to use the same system to ensure optimal uniformity.



### **6.3 Roles of the Different Parties**

The roles of the various people involved in the assessment need to be the following:

- **Medical Practitioners.**

As already been the doctors involved should only comment on impairment and not disability and explain that the final decision will be made by the company.

- **The Employer.**

The employer needs to supply full details of the job description of the employee and should take into account the Labour Relations Act. This implies workplace adaptation and the possibility of alternative assessment in the company.

- **The Patient.**

The patient should supply the company with complete details, usually on a standard form to give the company the necessary background information.

- **The Insurance Company.**

The insurance company should standardise the administration of claims management by obtaining reports according to the minimum format already described. This eliminates delays that can arise in obtaining detailed information. The company should also train their agents to explain the conditions of the policy contract to the client in an understandable way and also to get the agent involved in the claims assessment procedure. Policy contracts should also be rewritten in more user friendly terminology to enable the client to understand the policy.

- **Costs**

The costs of the initial investigations i.e. by a general practitioner or specialist are the responsibility of the claimant. If however, the company

requires a second opinion, this will be at the company's expense. It is accepted, that preparing reports on impairment for insurance companies takes longer than a normal consultation and therefore the fee for this service should be adjusted. The suggested fee for an impairment evaluation done by a Pulmonologist would include the clinical evaluation, lung function testing and effort ECG according to the Bruce Protocol. The fee will be adjusted annually in line with the LOA – South African Medical Association (SAMA) fee increases.

- **Confidentiality.**

Reports requested and paid for by the insurance industry remain the property of the company involved. The industry wishes to stress that this information remains strictly confidential and if disclosure of information is required, written permission from the clinician will first be obtained.

**REPORT SHEET**

IMPAIRMENT IN ACTIVITIES OF DAILY LIVING

I LEVELS OF IMPAIRMENT

**CATEGORY.**

1. No impairment. Functions as any normal person.
2. Mild impairment. Has difficulty with the specific activity, but can cope.
3. Moderate impairment. Can only do the specific activity with discomfort and effort.
4. Marked impairment. Needs assistance with the activity.
5. Extreme impairment. The specific activities are impossible to do.

II AREAS OF FUNCTION.  
IMPAIRMENT CATEGORY.

**Activity**

Self-care, personal hygiene	<ul style="list-style-type: none"> <li>- Bathing</li> <li>- Grooming                             <ul style="list-style-type: none"> <li>- Dressing</li> <li>- Eating</li> <li>- Eliminating</li> </ul> </li> </ul>	_____ _____ _____ _____
Communication	<ul style="list-style-type: none"> <li>- Hearing</li> <li>- Speaking</li> <li>- Reading</li> <li>- Writing</li> <li>- Using keyboard</li> </ul>	_____ _____ _____ _____ _____
Physical activity	Intrinsic <ul style="list-style-type: none"> <li>- Sitting</li> <li>- Standing</li> <li>- Reclining</li> <li>- Walking</li> <li>- Stooping</li> <li>- Squatting</li> <li>- Kneeling</li> <li>- Reaching</li> <li>- Bending</li> <li>- Twisting</li> <li>- Leaning</li> </ul>	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____
Functional	<ul style="list-style-type: none"> <li>- Carrying</li> <li>- Lifting</li> <li>- Pushing</li> <li>- Pulling</li> <li>- Climbing</li> <li>- Exercising</li> </ul>	_____ _____ _____ _____ _____
Sensory function	<ul style="list-style-type: none"> <li>- Hearing</li> </ul>	_____

- Seeing \_\_\_\_\_
- Tactile feeling \_\_\_\_\_
- Tasting \_\_\_\_\_
- Smelling \_\_\_\_\_
  
- Hand functions
  - Grasping \_\_\_\_\_
  - Holding \_\_\_\_\_
  - Pinching \_\_\_\_\_
  - Percussive movements \_\_\_\_\_
  - Sensory discrimination \_\_\_\_\_
  
- Travel
  - Riding \_\_\_\_\_
  - Driving \_\_\_\_\_
  - Travelling by airplane,train or car \_\_\_\_\_
  
- Sexual function
  - Participating in desired sexual activity \_\_\_\_\_
  
- Sleep
  - Having a restful sleep pattern \_\_\_\_\_
  
- Social and recreational activities
  - Participating in individual or group activities \_\_\_\_\_
  - Sports \_\_\_\_\_
  - Hobbies \_\_\_\_\_

**Signature:**

**Physician:**

**Date:**

PATIENT DATA

**Name:**

**D.O.B.**

**Policy Number:**

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