

GUIDELINES FOR ASSESSING DISABILITY DUE TO PULMONARY DISORDERS

Effective date 28 July 2021

INDEX

Content

1. Introduction
2. Background to the guidelines
3. Distinguishing between Impairment and disability.
 - 3.1 Impairment
 - 3.2 Disability
4. Assessing disability
 - 4.1 Disability clause conditions
 - 4.2 Total and permanent disability
 - 4.3 Availability of employment
5. Assessing respiratory functional impairment
 - 5.1 Special investigations
 - 5.2 Evaluating permanent pulmonary impairment
 - 5.3 Correlation of functional impairment with ability to perform tasks
 - 5.4 Content of the clinical report
6. Protocol for evaluating potential claims
 - 6.1 The treating general practitioner or pulmonologist
 - 6.2 Flow diagram
 - 6.3 Roles of the different parties

Appendix: Report sheet

References

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 a leading 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 such as:

- 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 and 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. BACKGROUND TO THE GUIDELINES

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 previous Life Office's Association (LOA), via its medical and underwriting committee, initiated contact between the S.A. Thoracic Society (SATS) with the aim of addressing the concerns that existed. 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 condition. The workshop that was held addressed areas of differences by way of literature reviews 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 representing the LOA and pulmonologists representing SATS. The guidelines for assessing disability were reviewed by the participants as well as members of the SATS Council. Alterations were included and the final document was accepted and submitted for publication.

The LOA guideline has been used as a basis for this version and updates and revisions were made with input from members of the ASISA Medical & Underwriting Committee as well as the Claims Standing Committee .

DISTINGUISHING BETWEEN DISABILITY AND IMPAIRMENT

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

3.1 IMPAIRMENT

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 and those 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, gender 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 defines 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. 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 (3).

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. 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 their 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 four.

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 insurer concerned. This will be done by the insurer’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 include 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, three 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

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 DISABILITY

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 optimal 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:

The Guidelines below for Chronic Obstructive Pulmonary Disease (COPD) as suggested by the South African Thoracic Society should be followed.

Table 1- Treatment choices based on severity of disease

Severity of disease	Defining clinical features	Treatment recommendations
Mild COPD (GOLD A)	Confirmed spirometric post-bronchodilator obstruction (commonly will have mild to moderate severity of lung function (FEV1 >50%); minimal symptoms on effort (mMRC <2), CAT <10b; infrequent exacerbations (1 per year)	Short acting bronchodilator (SABA or SAMA) as needed for symptomatic relief
Moderate COPD (GOLD B)	Confirmed spirometric post-bronchodilator obstruction (lung function may be preserved or significantly reduced, FEV1 >50%); significant symptoms on effort (mMRC ≥2), or CAT >10; infrequent exacerbations (1 per year)	Long acting bronchodilator either LAMA or LABA; if inadequate response, try alternative agent or add a second bronchodilator; if no symptomatic benefit, withdraw second agent
Severe COPD (GOLD D)	Confirmed spirometric post-bronchodilator obstruction (commonly will have severe lung function reduction FEV1 <50%)a; severe symptoms on effort (mMRC ≥2), CAT >10; frequent exacerbations: 2 outpatient or 1 inpatient in past 12 months	Single bronchodilator LAMA; dual bronchodilator: LAMA/LABA or alternatively LABA/ICS; if not responding to dual agents, referral to specialist is advised

The guidelines below for chronic asthma suggested by SATS can be used as a basis for recommended treatment:

Intermittent	Chronic Persistent		
Mild	Mild	Moderate	Severe
I	II	III	IV

Daytime symptoms* ≤2/week	Daytime symptoms 3-4/week	Daytime symptoms >4/week	Daytime symptoms Continuous
Night symptoms** ≤1/month	Night symptoms 2-4/month	Night symptoms >4/month	Night symptoms Frequent
PEF ≥80%	PEF ≥80%	PEF 60-80%	PEF <60%

* Any cough, tight chest and wheeze

** any of cough, tight chest, wheeze and night waking

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 optimal 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 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 patient's 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 allied health professional / rehabilitation specialist, 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.

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 (FEV1) should be measured. The range of normal values can be found in the "Guides to The Evaluation of Permanent Impairment". (2)

If the FEV1/FVC ratio is below 0.7, the spirometry should be repeated after the patient has used an inhaled bronchodilator.

The FEV1/FVC ratio is helpful in the diagnosis of obstructive airways disease. The severity is judged on the basis of the absolute value of the FEV1 or the percentage of predicted of the FEV1.

- 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 (VO₂)

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 (PO₂)

This is rarely undertaken due to its invasive nature.

5.2 EVALUATING PERMANENT PULMONARY IMPAIRMENT

It is recommended that the criteria as defined in the American Medical Association's "Guides to the evaluation Of Permanent Impairment" are referred to as presented in the following table.

TABLE 5-4 Criteria for Rating Permanent Impairment due to Pulmonary Dysfunction^a

 Pulmonary Dysfunction					
CLASS	CLASS 0	CLASS 1	CLASS 2	CLASS 3	CLASS 4
WHOLE PERSON IMPAIRMENT RATING (%)	0	2%-10%	11%-23%	24%-40%	45%-65%
SEVERITY GRADE (%)		2 4 6 8 10 (A B C D E) (Minimal)	11 14 17 20 23 (A B C D E) (Mild)	24 28 32 36 40 (A B C D E) (Moderate)	45 50 55 60 65 (A B C D E) (Severe)
HISTORY	No current symptoms <i>and/or</i> intermittent Dyspnea that does not require treatment	Dyspnea controlled with intermittent or continuous treatment <i>or</i> intermittent, mild Dyspnea despite continuous treatment	Constant mild Dyspnea despite continuous treatment <i>or</i> intermittent, moderate Dyspnea despite continuous treatment	Constant moderate Dyspnea despite continuous treatment <i>or</i> intermittent, severe Dyspnea despite continuous treatment	Constant severe Dyspnea despite continuous treatment <i>or</i> intermittent, extreme Dyspnea despite continuous treatment
PHYSICAL FINDINGS	No current signs of disease	Physical findings not present with continuous treatment <i>or</i> intermittent, mild physical findings	Constant mild physical findings despite continuous treatment <i>or</i> intermittent, moderate findings	Constant moderate physical findings despite continuous treatment <i>or</i> intermittent, severe findings	Constant severe physical findings despite continuous treatment <i>or</i> intermittent, extreme findings

Class	Class 0	Class 1	Class 2	Class 3	Class 4
Whole person impairment rating (%)	0	2 to 10	11 to 23	24 to 40	45 to 65
Severity grade					
Percent impairment		2 4 6 8 10	11 14 17 20 23	24 28 32 36 40	45 50 55 60 65
Grade		A B C D E	A B C D E	A B C D E	A B C D E
History	No symptoms currently and/or intermittent dyspnea that does not require treatment	Dyspnea controlled with intermittent or continuous treatment or intermittent mild dyspnea despite continuous treatment	Constant mild dyspnea despite continuous treatment or intermittent moderate dyspnea despite continuous treatment	Constant moderate dyspnea despite continuous treatment or intermittent severe dyspnea despite continuous treatment	Constant severe dyspnea despite continuous treatment or intermittent extreme dyspnea despite continuous therapy
Physical findings	No current signs of disease	Physical findings not present with continuous treatment or intermittent mild physical findings	Constant mild physical findings despite continuous treatment or intermittent moderate findings	Constant moderate physical findings despite continuous treatment or intermittent severe findings	Constant severe physical findings despite continuous treatment or intermittent extreme findings
Objective tests					
FVC	≥80% of predicted and	70 to 79% of predicted or	60 to 69% of predicted or	51 to 59% of predicted or	Below 50% of predicted or
FEV ₁	≥80% of predicted and	65 to 79% of predicted or	55 to 64% of predicted or	45 to 54% of predicted or	Below 45% of predicted or
FEV ₁ /FVC	FEV ₁ /FVC >LLN or >75% of predicted and				
DLCO	DLCO ≥75% of predicted or	65 to 74% of predicted or	55 to 64% of predicted or	45 to 54% of predicted or	Below 45% of predicted or
VO ₂ max	>25 mL/kg/min or >7.1 METs	22 to 25 mL/kg/min or 6.3 to 7.1 METs	18 to 21 mL/kg/min or 5.1 to 6.2 METs	15 to 17 mL/kg/min or 4.3 to 5 METs	<15 mL/kg/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 insurer 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 of an individuals' 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 FEV1 correlates better with exercise capacity in persons with obstructive lung disease than the arterial PO₂. In broad terms, persons with an FEV1 greater than 60% of predicted are able to work whereas those with an FEV1 of less than 45% are generally unable to work. Most people with an FEV1 greater than 2 litres are able to work.
- Exercise capacity is measured by the uptake of oxygen (VO₂) in mL(kg.min) or in METS. Exercise VO₂ determination can be undertaken on individuals who have mild or moderate (class 2 or 3) impairments. Those individuals with a VO₂ of 25mL(kg.min) can perform most jobs. With a VO₂ 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 VO₂ for an eight hour period. The following table shows a relationship between work capacity and oxygen consumption.

Work intensity for 70kg person	Oxygen consumption	Excess energy expenditure
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 PO₂ of less than 55 mm Hg is strong evidence of a severe impairment.
- A six 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
 - Gender
 - Date of birth
 - 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 the merits of the disability claim.

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 are recommended for 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.

6.2 ROLES OF THE DIFFERENT PARTIES

The roles of the various people involved in the assessment are as follows:

- **Medical Practitioners**

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

- **The Occupational Therapist**

An Occupational Therapist (OT) may be appointed by the Insurer to assist with a functional capacity evaluation, particularly for occupational disability claims. The OT should be carefully briefed on what is required of them and should provide the insurer with a detailed report of the claimant's abilities and limitations. This is done via standardised testing, interviewing and through obtaining collateral information. The OT provides feedback on the job match and whether any accommodations/adaptations would allow the claimant to continue working but does not give an opinion on the outcome of the claim. The cost of the OT evaluation is usually borne by the insurer.

- **The Employer**

The employer should supply full details of the job description of the employee and take into account the Labour Relations Act. This implies workplace adaption and the possibility of realignment within the company.

- **The Patient**

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

- **The Insurer**

The insurer 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.

- **Costs**

The costs of the initial investigations i.e by a general practitioner or specialist are usually the responsibility of the claimant. If however, the insurer requires a second opinion, this will be at the insurer's expense. It is accepted that preparing reports on impairment for insurers takes longer than a normal consultation, and therefore the fee for this service should be adjusted. The fee for an impairment evaluation conducted by a Pulmonologist would generally include the clinical evaluation, lung function testing and effort ECG according to the Bruce Protocol. See this link for a description of the Bruce Protocol: https://en.wikipedia.org/wiki/Bruce_protocol.

HISTORY OF AMENDMENTS

Effective date	Amendments

Responsible Senior Policy Advisor: Anna Rosenberg

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		- Bathing - Grooming - Dressing - Eating - Eliminating	
Communication		- Hearing - Speaking - Reading - Writing - Using Keyboard	
Physical activity	Intrinsic	- Sitting - Standing - Reclining - Walking - Stooping - Squatting - Kneeling - Reaching - Bending - Twisting - Leaning	
Functional	Carrying	- Lifting - Pushing - Pulling - Climbing - Exercising	



Sensory function	Hearing	- 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	
<u>Name:</u>	<u>D.O.B.</u>
<u>Policy Number:</u>	

REFERENCES

1. World Health Organisation. International Classification of Impairments, Disabilities, and Handicaps
Geneva, Switzerland: World Health Organisation; 1980.
2. Guides to the Evaluation of Permanent Impairment, Fourth Edition. American Medical Association; 1995.
3. Evaluation of impairment/disability secondary to respiratory disease. A statement of the ATS. *Am Rev Respir Dis.* 1986; 133:1205-9.
4. Guidelines for the management of chronic obstructive pulmonary disease. Working group of the South African Pulmonology Society *S. Afr. Med. J* 1998;88: 999-1010.
5. South African Thoracic Society- Personal Communication
6. https://goldcopd.org/wp-content/uploads/2019/12/GOLD-2020-FINAL-ver1.2-03Dec19_WMV.pdf
7. Abdool-Gaffar, M.S., et al., *Management of chronic obstructive pulmonary disease—A position statement of the South African Thoracic Society: 2019 update.* *Journal of Thoracic Disease*, 2019. 11(11): p. 4408-4427.
8. https://pulmonology.co.za/wp-content/uploads/2016/11/Guideline_8.pdf