Health Assessment Service

Personal Independence Payment

Health assessment report

Claimant details

Name	[redacted]
National Insurance number	[redacted]
Date of birth	[redacted]
Benefit type	Personal Independence Payment
Date report was completed	8 April 2024
Name of Healthcare Professional	[redacted]

Health assessment

Select the type of assessment

Type of assessment	Telephone
Date of assessment	05/04/2024

Additional attendees

Attendee 1

Name: Attended alone

Relationship to claimant: N/A

Evidence

All further medical evidence submitted prior to the {05/04/2024} have been reviewed and considered. The following documents have been used when assessing and justifying the current level of functional restrictions:

Claimant management sheet (CMS)
PIP2 23/01/2024
Letter from Ear, Nose and Throat (ENT) specialist 25/10/2022.
Letter from ENT 25/10/2022 referral letter.
EConsult 05/07/2021
Report respiratory medication no date on HAS 23/01/2024
Report respiratory medication 22/09/2022

All evidence read and considered even if not listed in this section.

No further evidence presented during the assessment.

Identity confirmed using the following:
Full name – [redacted]
Date of birth – [redacted]
NINO – [redacted]
Name of benefit - PIP

The following abbreviations may be included within the report: HCP (Healthcare Professional), Functional History (FH), History of conditions (HOC), Social and occupational History (SOH), Informal Observations (IO), Mental state examinations (MSE), Further evidence (FE), Community psychiatric nurse (CPN), Overwhelming psychological distress (OPD), Cognitive Behavioural Therapy (CBT), Occupational therapist (OT), Post traumatic stress disorder (PTSD), Emotional unstable personality disorder (EUPD) and CAMHS (child and adolescent mental health services). Medication and treatment/therapy (MT) and Irritable Bowel Syndrome (IBS).

History of condition

The scope of the assessment was explained to the claimant and the claimant gave verbal consent to proceed.

Obstructive sleep apnoea. Was diagnosed by a specialist in 2007 but did not have a sleep study until 2022. He has been given a continuous positive airway pressure (CPAP) machine. He was referred for further sleep studies. He had surgery for deviated septum (dividing wall in nose) in 2006 and he also had a revision 1 year ago. He had his full sleep study and this showed a spike in central events - he had a sleep endoscopy (camera) last Tuesday, there is an issue with his tongue base which could be affecting his apnoea and he needs to have surgery for this. He is under the care of the specialist and is awaiting surgery. He states that he has been diagnosed with central sleep apnoea and he has been advised to start using a full ventilator (Bi-level positive airway pressure BPAP) and is due further studies for this at the end of the month. He will spend time in hospital for this for 3 nights. He states that he is able to breathe better since his surgery last year. However with his sleep apnoea, he is suffering with fatigue daily and this has always been a problem. He thought that his fatigue was due to exercising but still suffers with this when he is not exercising. This becomes worse mid morning, he takes cold showers to wake up and needs to have a sleep at 3pm for 20 minutes and he will always set an alarm for this but occasionally at times will sleep for 30-45 minutes. This helps him to reset his energy levels and to refocus. He states that his symptoms have worsened as he has gotten older - over the last 10 years. He takes magnesium supplements at night for this to help with the fatigue. He suffers with loss of concentration and focus daily. Most days, 3-4 days a week he wakes up with a headache. He has never had to be an inpatient as a result of this other than his sleep studies. He states that he has stepped onto the road twice without looking due to loss of focus, last time was in 2023 sometime, no injuries occurred.

Fibromyalgia. He was diagnosed by his GP in 2012 and started on pain relief. He tried different medications for pain which did not work. He then took Tramadol (pain relief) for 4 years, he then moved to America for a while, took pain relief there

but came off this. He no longer takes Tramadol but does use over the counter pain relief. He was referred to pain management but did not attend as the referral was lost - he states that he has since been re-referred to the pain management service 1 month ago. He states that his GP has discussed him being referred to weight managed as he nearly obese on the weight scale (BMI - body mass index). He has not been referred to any other services. Day to day he experiences symptoms of forgetfulness - fibro fog, feeling overpowered with pain in his shoulders (worse on the right side), lower right side of his back and hip as well as both ankles where he has a lot of tension when he walks. His knees and elbows are ok. He suffers with fatigue also but is not sure what is related to his sleep apnoea. He feels that his symptoms have worsened over time, more so since 2021. He reports no variability. He has not needed to stay in hospital as a result of this.

Myofacial pain syndrome (long term pain condition were pressure on areas - trigger points, causes pain). He was diagnosed by a specialist last year. He was referred to an orthodontist due to him wearing a mouth guard for 20 years but there is no other treatment planned. He experiences pain symptoms - he is unable to differentiate this from his fibromyalgia pain and this follows the same above history. He takes over the counter pain relief but feels that his left sided jaw pain is the worst.

Chronic back pain. He was diagnosed by his GP in 2004 and had several appointments with physiotherapy. He last saw the physio a month ago, he was given some home exercises and will have a follow up in 3 months. He takes over the counter pain relief. He had a scan of his back in 2015 which showed a disc bulge in lumber spine at L4. He did see a specialist in 2011 and 2015 for his back but not since. He is under GP care. He states that this is the most frustrating pain of all. It is in his lower back - states that suffers with tilted pelvis when he walks which causes a strain on his lower back. Running is also painful and now only does cross training at the gym. Sitting is also painful, needs to stand up after 30 minutes. When he is asleep, he has to lay in his side as it hurts to lay on his back - as he will suffer with radiating pain down to his thigh. He has not had

surgery or pain relief injections for his back. He has not needed to attend hospital as an inpatient for this back but did attend the urgent care centre after attending the gym, following a warm down stretch where he felt a pop in his back - he needed to rest at home for 2 weeks on pain relief. This was in 2013. His pain overall has worsened over time since 2021. There is no variability in his symptoms day to day.

Reports issues with muscle flinching in his right arm since 2016. This can also occur in his left arm. This is being evaluated as it could be a result of central nervous system activity. He has spoken with his sleep specialists about this and his partner has told him that he has limb flinching in his sleep. He has not been diagnosed with anything as yet but he will be assessed when he has his further sleep studies. He is not sure if he has restless leg syndrome. He has not been given any medication for this. With his right arm flinching, this is daily and hourly, it is not constant. His left arm is left often but is still hourly. He feels that the muscle is weaker on his right forearm - it feels weaker when he pushes it. The leg flinching occurs just at night time. He feels the symptoms are more frequent now but intensity has not worsened. This will cause him to do involuntary mouse clicks when on the computer or press the wrong button on his phone. This has not resulted in him needing to attend hospital. He later states that he has started to flinch his bicep on right arm, this started middle of last year, this is occurs hourly and is variable within the hour. There is no trigger for these flinches.

Temporomandibular (jaw) joint pain in the last 1990s, leading to jaw soreness due to bruxism (teeth grinding) , a result of night time teeth grinding. Reports that he has been wearing a mouth guard for 20 years which was prescribed, this has moved his jaw forward and has affected his speech. He has been seeing the dentist for this over the years. He has been referred to an orthodontist for this now due to movement in his jaw. He suffers with left sided jaw pain all of the time and feels exhausted as a result of this. He states that his jaw is asymmetric (not symmetrical) to his left side. He does not feel that he can open and close his jaw properly as it is too tight. Some days it is ok, some days he cannot talk and is

more fatigued. He then states that his talking ability is more due to his fatigue, 1-2 times a week more so towards the end of the day. He has sliced his tongue open in the past (2003 and attended A&E - had some stitches at the time) and well as biting his lips almost daily when eating his food. He has not needed to attend A&E since slicing his tongue open in 2003.

Depressive disorder. This first started when he had severe acne in his early 20's. He then moved to London for a job and had a difficult manager, the stress of moving to London by himself, exacerbated his stress. He was diagnosed with work related stress and then anxiety. He was off work for 4 months in 2010. He was then diagnosed with depression. His still has acne but this has improved and manages this himself. He was prescribed anti depressants in 2010 for 6 months which helped, he got better but was off the following year with depression. He was then better for 4 years. His depression has since worsened due to his fatigue and pain in the last couple of years and this was compounded by a break up in 2022. He states that he saw a psychiatrist in 2022, was seen by them for 6 months - on 3 occasions. He has not seen anyone since then for his mental health other than his GP. He last took medication for his mental health (anti depressant) in early 2023 for 3 months. He does not feel that the medication has worked, he does feel that he may need therapy but there are no other plans for treatment. He is under GP care. He later states that he was given an anti anxiety medication by his GP in 1998 which he took for 3 months. Day to day he experiences symptoms of forgetfulness, slurred speech, problems organising his thoughts in a coherent way. He has negative thoughts of past and overthinks these when he is alone, in a meditative state. This results in him contemplating his life. He does not have any hallucinations or intrusive thoughts and states that he is in control of his thoughts. He states that he would never commit suicide or harm himself. He did have passing thoughts of committing suicide 2022 but did look at how he could take his own life on one occasion in September 2022 as he was in a dark place after a breakup, this was reactive at the time and more about ending the heart break in which he was able to talk himself out of. He has protective factors of his

faith and went to his place of worship the next day after this thought in 2022. He also has protective factors of his partner. He has not felt this way since then. He has never been admitted to hospital or been an inpatient for his mental health. He has never been under the CRISIS team or home treatment team. His psychiatrist at the time was aware of his suicidal ideation. He reports no variability in his symptoms in relation to his mental health, he feels that his mental health has stayed the same since he last saw his GP about this. He takes no current medication.

He was referred for an assessment for autism in 2021. He however moved out of the area and this did not occur. He was referred by a psychiatrist at the time. He states that he was diagnosed with dyslexia as a teenager and his psychiatrist thought a further assessment may have been needed after he filled in some questionnaires. There are no plans as yet to refer him again for an assessment. He states that he suffers with forgetfulness, slow speech, confusion, not thinking clearly, memory problems, problems with social interaction, problems with picking up social queues. He states that this is not variable. His dyslexia was diagnosed by an educational psychologist and he had support in school - coloured sheets and extra time in exams were given. When he went to university he had dragon software to read things out for him. He states that he no longer uses any colour screens or software to help him read. He went to a main stream school. He takes no medication for this.

No other medical problems reported during the assessment.

Current medication or treatment

Tramadol 50 mg for moderate to strong pain relief - stopped some time ago

Takes no prescribed medication.

Over the counter (OTC):

Ibuprofen 200 mg x2 three times a day for anti inflammatory pain relief.
Paracetamol 500 mg x2 as required for mild pain relief. Will take this instead of Ibuprofen sometimes.
Magnesium powder supplements taken daily to help

with fatigue

Side effects: none

Efficacy: He feels that the pain killers to help in part.

Therapies: He is doing home physio exercises himself at night time before bed time.

Uses CPAP machine 2-3 nights a week for sleep apnoea. Has not used this for a month. He is able to set this up and use it himself. He does not use this as he knows it is not working as he needs the BIPAP.

Social and occupational history

Accommodation: He lives in a flat - second floor, accessed by stairs. He lives by himself. The shower is over the bath.

Aids and adaptation: None

Education: He went to a normal school, had coloured filters for reading and extra time in exams. He then attended university after A 'levels and a foundation degree. He used dragon software to read things out for him in lessons whilst at university for his bachelor degree. He studied software engineering as a bachelor degree. He then did an Masters in Business Administration (MBA) and graduated in 2021 - he was supported by his Masters Tutors as per masters degree candidates and this was all coursework online. He did not use any aids whilst doing his MBA.

Work: He stopped working in December 2023, he was a programme manager for Amazon full time and prior to this a data analyst and worked in analytics over the years, including for Google. He left his role in December as he was performing poorly. Amazon did not provide him with any occupational health input and let him go without supporting him due to his dyslexia causing fatigue. He is currently looking for work, has applied for over 100 jobs, with blue chip companies and has had 3 interviews so far. He states the job market is currently tough.

Driving: He has a driving licence but was advised not to drive by the sleep apnoea service due to his ongoing tests in 2022. He stopped driving in 2012 as he did not need a car as he lived in central London.

How else do they get around: He uses public transport and walks places. As he is not working he stays at home more but is he has to go out anywhere he will use the underground and buses or walks places.

Pets: None.

Caring responsibilities: None.

Hobbies/pastimes: He plays chess on his phone to keep his brain active. He tries to read in his spare time. He is looking for work and applying for jobs constantly. He likes to spend his time exercising, on the cross trainer and he has accessed courses as he is on UC, an engineering one to give himself more employment opportunities. He likes to go for walks.

Housework: He does do housework and tries to not let the place get too messy. He does his own laundry and dishes. Hoovering is a problem due to back pain. He does do this and does clean his bath but has back pain.

Shopping: It is too difficult to carry shopping due to pain in his back and has food deliveries. When this comes he puts this away himself.

Who completed the questionnaire: Himself.

Any formal or informal support received: None and manages himself.

How do they spend their day, any difference at the weekends? He spends time with his partner at the weekends at times and during the weekdays.

Preparing food

Functional history for preparing food

He will prepare things like pasta, cuts up some onions normally. He makes himself quite simple meals and relies on himself for this only, preferring it this way. He has had one incident where he has cut his index finger where he needed a plaster whilst chopping. States this was due to a muscle flinch. He

	does not use any aids. he does not need prompting. He is able to make teas and coffees, using the kettle.
How well can the claimant cook food?	(1a) Can prepare and cook a simple meal unaided
What is the reason for this answer?	PIP2 - Reports issues with muscle flinching in his right arm. HOC shows that he is under GP care for his back and fibromyalgia, having just been referred to pain clinic. MT shows that he takes no prescribed pain relief and only OTC anti inflammatory pain and as required mild pain relief. HOC shows arm flinching but there is no FE to support significant restriction with this. FH in activity 4 - washing and bathing, shows that he still wet shaves himself which is unlikely to support significant risk from any flinching when there is no reported trigger. The above FH reports that he has just cut himself once as a result of his flinching when preparing food in the kitchen. HOC shows that he has sleep apnoea and whilst he reports fatigue as an issue, he is only needing to take a 20 minute nap in the day normally to feel refreshed. SOH shows that he likes to exercise and go for walks. It also shows that is doing housework, is looking for work and was working full time until 4 months ago having lost his job due to his performance and he did not have any occupation health input. IOs showed no that he did not appear fatigued or tired during the assessment. There was no expression of pain, breathlessness or wheeze. HOC shows that he takes no medication for this mental health, is under GP care and there are no further plans for treatment. There is no formal diagnosis of Autism and although he had support at school, this was for his dyslexia and he has been able to obtain a MBA in recent years without any significant support or aids. SOH shows that he has been able to achieve a degree and a post grad MBA. He has been working in responsible roles within blue chip companies.

Although he lost his job in December 2023, he did not have any occupational health input prior to this. There was no evidence in his MSE to show any restriction from a mental health or cognitive perspective.

There is no other evidence to support restriction.

Any reported restriction in his questionnaire is likely to be medically inconsistent.

It is likely that he can prepare and cook a simple meal unaided, on the majority of days, ensuring safety, timeliness, that it is done to an acceptable standard and repeatedly.

Taking nutrition

Functional history for taking nutrition

He is able to take drinks himself. He does eat and drink by himself, does not use any adapted cutlery, does not need prompting and has no issues swallowing or chewing other than biting his lip or cheek. He does not need to be prompted.

Which of these describes how well the claimant can take nutrition?

(2a) Can take nutrition unaided

What is the reason for this answer?

PIP2 - he bites into his tongue and cheeks due to temporomandibular joint pain leading to jaw soreness.

There is no HOC to support dietetic support at present and there is no reported weight loss. He takes no medication for this mental health, is under GP care and there are no further plans for treatment. There is no formal diagnosis of autism. There was no evidence in his MSE to show any restriction from a mental health or cognitive perspective. There is no other evidence to support restriction.

Whilst HOC shows Temporomandibular joint pain and referral to an orthodontist, he has not been to A&E since 2003 with any oral injuries despite reporting that he bites his lip daily when eating. As above, there is no evidence of dietic support for this,

special diets or alternative food administration routes.

HOC shows arm flinching but there is no FE to support significant restriction with this. FH in activity 4 - washing and bathing, shows that he still wet shaves himself which is unlikely to support significant risk from any flinching when there is no reported trigger.

This is medically consistent with the FH which shows no significant restriction.

It is likely that he can take nutrition unaided, on the majority of days, ensuring safety, timeliness, that it is done to an acceptable standard and repeatedly.

Managing therapy

Functional history for managing therapy

He takes his own medication himself and requires no prompting, assistance and uses no aids.

Which of these describes how well the claimant can manage therapy or monitor a health condition?

(3a) Either does not receive medication or therapy or need to monitor a health condition, or can manage medication or therapy or monitor a health condition unaided

What is the reason for this answer?

PIP2 - reports no issues.

HOC shows that he takes no medication for this mental health, is under GP care and there are no further plans for treatment. There is no formal diagnosis of autism. There was no evidence in his MSE to show any restriction from a mental health or cognitive perspective. There is no other evidence to support restriction.

MT shows that he takes no prescribed medication and OTC pain relief only. He is independent with his home physio exercises as he is with his CPAP machine.

Whilst HOC shows Temporomandibular joint pain and referral to an orthodontist, he has not been to A&E since 2003 with any oral injuries despite reporting that he bites his lip daily when eating.

HOC shows arm flinching but there is no FE to support significant restriction with this. FH in activity 4 - washing and bathing, shows that he still wet shaves himself which is unlikely to support significant risk from any flinching when there is no reported trigger.

This is medically consistent with the FH and questionnaire which shows no significant restriction.

It is likely that he either does not receive medication or therapy or need to monitor a health condition, or can manage medication or therapy or monitor a health condition unaided, on the majority of days, ensuring safety, timeliness, that it is done to an acceptable standard and repeatedly.

Washing and bathing

Functional history for washing and bathing	He is able to get into the bath himself, then washes himself and gets out of he time bath himself. He does wet shave himself normally and does not normally cut himself as a result of flinching. He requires no prompting, has no assistance and uses no aids.
Which of these describes how well the claimant can wash and bathe?	(4a) Can wash and bathe unaided
What is the reason for this answer?	PIP2 - reports problems with balance. Suffers with stiffness and pain. HOC shows that he is under GP care for his back and fibromyalgia, having just been referred to pain clinic. MT shows that he takes no prescribed pain relief and only OTC anti inflammatory pain and as required mild pain relief. HOC shows arm flinching but there is no FE to support significant restriction with this. FH shows that he still wet shaves himself which is unlikely to support significant risk from any flinching when there is no reported trigger. HOC shows that he has sleep apnoea and whilst he

reports fatigue as an issue, he is only needing to take a 20 minute nap in the day normally to feel refreshed. SOH shows that he likes to exercise and go for walks. It also shows that is doing housework, is looking for work and was working full time until 4 months ago having lost his job due to his performance and he did not have any occupational health input.

IOs showed no that he did not appear fatigued or tired during the assessment. There was no expression of pain, breathlessness or wheeze.

HOC shows that he takes no medication for this mental health, is under GP care and there are no further plans for treatment. There is no formal diagnosis of Autism and although he had support at school, this was for his dyslexia.

There was no evidence in his MSE to show any restriction from a mental health or cognitive perspective.

This is consistent with the lack of reported restriction in his FH.

The reported restriction in the questionnaire is likely to be medically inconsistent.

There is no other evidence to support restriction.

It is likely that he can wash and bathe unaided, on the majority of days, ensuring safety, timeliness, that it is done to an acceptable standard and repeatedly.

Managing toilet needs

Functional history for managing toilet needs	Reports no issues with getting on and off the toilet, cleaning himself and does not have any incontinence or wear incontinence pads. He does not require prompting.
Which of these describes how well the claimant can manage toilet needs?	(5a) Can manage toilet needs or incontinence unaided

What is the reason for this answer?

PIP2 - reports no issues.

HOC shows that he is under GP care for his back and fibromyalgia, having just been referred to pain clinic. MT shows that he takes no prescribed pain relief and only OTC anti inflammatory pain and as required mild pain relief.

HOC shows arm flinching but there is no FE to support significant restriction with this. FH shows that he still wet shaves himself which is unlikely to support significant risk from any flinching when there is no reported trigger.

HOC shows that he has sleep apnoea and whilst he reports fatigue as an issue, he is only needing to take a 20 minute nap in the day normally to feel refreshed. SOH shows that he likes to exercise and go for walks. It also shows that is doing housework, is looking for work and was working full time until 4 months ago having lost his job due to his performance and he did not have any occupational health input.

IOs showed no that he did not appear fatigued or tired during the assessment. There was no expression of pain, breathlessness or wheeze.

HOC shows that he takes no medication for this mental health, is under GP care and there are no further plans for treatment. There is no formal diagnosis of Autism and although he had support at school, this was for his dyslexia.

There was no evidence in his MSE to show any restriction from a mental health or cognitive perspective.

This is consistent with the lack of reported restriction in his FH and questionnaire.

There is no other evidence to support restriction.

It is likely that he can manage toilet needs or incontinence unaided, on the majority of days, ensuring safety, timeliness, that it is done to an acceptable standard and repeatedly.

Dressing and undressing

Functional history for dressing and undressing	He will finds getting his socks on more difficult as his hamstrings are tight due to his fibromyalgia and he finds himself off balance needing to sit on the bed to dress. He will still dress himself despite pain, leaning forward as required. He requires no aids, assistance of prompting to dress or with choice of clothing.
Which of these describes how well the claimant can dress and undress?	(6a) Can dress and undress unaided
What is the reason for this answer?	PIP2 - reports no issues. HOC shows that he is under GP care for his back and fibromyalgia, having just been referred to pain clinic. MT shows that he takes no prescribed pain relief and only OTC anti inflammatory pain and as required mild pain relief. HOC shows arm flinching but there is no FE to support significant restriction with this. FH shows that he still wet shaves himself which is unlikely to support significant risk from any flinching when there is no reported trigger. HOC shows that he has sleep apnoea and whilst he reports fatigue as an issue, he is only needing to take a 20 minute nap in the day normally to feel refreshed. SOH shows that he likes to exercise and go for walks. It also shows that is doing housework, is looking for work and was working full time until 4 months ago having lost his job due to his performance and he did not have any occupation health input. IOs showed no that he did not appear fatigued or tired during the assessment. There was no expression of pain, breathlessness or wheeze. HOC shows that he takes no medication for this mental health, is under GP care and there are no further plans for treatment. There is no formal diagnosis of Autism and although he had support at school, this was for his dyslexia.

There was no evidence in his MSE to show any restriction from a mental health or cognitive perspective.

This is consistent with the lack of reported restriction in his questionnaire.

The reported restriction in the FH is likely to be medically inconsistent and is likely to be mitigated by sitting down to dress which is not in scope.

There is no other evidence to support restriction.

It is likely that he can dress and undress unaided, on the majority of days, ensuring safety, timeliness, that it is done to an acceptable standard and repeatedly.

Communicating verbally

Functional history for communicating verbally	He states he gets by daily with communicating with people. He does not use any aids. He is better when he is at work but states that people used to ask him to repeat himself. He has been told that he mumbles and slurs his words. He talks too fast. He gets by, repeating himself. He does struggle engaging in loud environments as he cannot speak loud enough.
Which of these describes how well the claimant can communicate verbally?	(7a) Can express and understand verbal information unaided
What is the reason for this answer?	PIP2 - reports issues due to obstructive sleep apnoea, resulting in slurred speech and due to a mouth guard that he has been wearing for 20 years, this has affected his speech. HOC shows that he takes no medication for this mental health, is under GP care and there are no further plans for treatment. There is no formal diagnosis of Autism and although he had support at school, this was for his dyslexia and he has been able to obtain a MBA in recent years without any significant support or aids. SOH shows that he has been able to achieve a

	degree and a post grad MBA. He has been working in responsible roles within blue chip companies. Although he lost his job in December 2023, he did not have any occupational health input prior to this. There was no evidence in his MSE to show any restriction from a mental health, communication or cognitive perspective. Whilst HOC shows a history of Temporomandibular (jaw) joint pain and fatigue, IO showed that he was communicative, was talkative, spoke in context, was easily understood, spoke at a normal rate and was able to understand the assessors questions. This was despite the assessment taking 2 hours and 20 minutes. There is no other evidence to support restriction. The reported restriction in the questionnaire and FH is likely to be medically inconsistent. It is likely that he can express and understand verbal information unaided, on the majority of days, ensuring safety, timeliness, that it is done to an acceptable standard and repeatedly.

Reading and understanding signs, symbols and words

Functional history for reading and understanding signs, symbols and words	He states that he used to use a screen filter and dragon software and does not use any aids at all now. He is able to read unaided for 20 minutes without the need to stop. He uses no aids or specialist software when he is using his lap top when applying for jobs.
Which of these describes how well the claimant can read and understand signs, symbols and words?	(8a) Can read and understand basic and complex written information either unaided or using spectacles or contact lenses
What is the reason for this answer?	PIP2 - reports no issues. HOC shows no formal diagnosis of Autism and although he had support at school, this was for his dyslexia and he has been able to obtain a MBA in

	recent years without any significant support or aids. SOH shows that he has been working in responsible roles within blue chip companies. Although he lost his job in December 2023, he did not have any occupational health input prior to this. There was no evidence in his MSE to show any restriction from a mental health or cognitive perspective. Whilst SOH shows the use of aids whilst at school and the use of software for his dyslexia, FH shows no recent use of these. There is no other evidence to support restriction. This is consistent with no restriction being reported in the questionnaire and the ability to complete this task unaided in his FH. It is likely that he can read and understand basic and complex written information either unaided or using spectacles or contact lenses, on the majority of days, ensuring safety, timeliness, that it is done to an acceptable standard and repeatedly.

Engaging face to face

Functional history for engaging face to face	He spends time with his girlfriend. He will attend appointments by himself and is able to engage with people on the way whilst using public transport and will have a conversation with them if they ask for directions. He was able to engage with people at work. He gets on better engaging with people in general if he is outdoors as they can hear him better. He has been engaging with people face to face for interviews without support as well as the job centre and meeting with the advisor unaided.
Which of these describes how well the claimant can engage face to face?	(9a) Can engage with other people unaided
What is the reason for this answer?	PIP2 - reports that he has a depressive disorder and has been been through an assessment for autism.

HOC shows that he takes no medication for this mental health, is under GP care and there are no further plans for treatment. There is no formal diagnosis of Autism and although he had support at school, this was for his dyslexia.

SOH shows that he has been working in responsible roles within blue chip companies. Although he lost his job in December 2023, he did not have any occupational health input prior to this.
There was no evidence in his MSE to show any restriction from a mental health, communication or cognitive perspective.

IO showed that he was communicative, was talkative, spoke in context, was easily understood, spoke at a normal rate and was able to understand the assessors questions. This was despite the assessment taking 2 hours and 20 minutes.

There is no other evidence to support restriction.

This is overall consistent with the lack of restriction indicated on the FH.

Any reported restriction in the questionnaire is likely to be medically inconsistent.

It is likely that he can engage with other people unaided, on the majority of days, ensuring safety, timeliness, that it is done to an acceptable standard and repeatedly.

Budgeting

Functional history for budgeting	He looks after his own finances and money without any support or help and is able to budget acordingly.
Which of these describes how well the claimant can budget?	(10a) Can manage complex budgeting decisions unaided
What is the reason for this answer?	PIP2 - reports no issues. HOC shows that he takes no medication for this mental health, is under GP care and there are no

further plans for treatment. There is no formal diagnosis of Autism and although he had support at school, this was for his dyslexia.
SOH shows that he has been working in responsible roles within blue chip companies. Although he lost his job in December 2023, he did not have any occupational health input prior to this. He has been able to complete a MBA in recent years.
There was no evidence in his MSE to show any restriction from a mental health or cognitive perspective.

This is overall consistent with the lack of restriction indicated on the FH and questionnaire.

It is likely that he can manage complex budgeting decisions unaided, on the majority of days, ensuring safety, timeliness, that it is done to an acceptable standard and repeatedly.

Planning and following journeys

Functional history for planning and following journeys	He is able to plan his own journeys when he has to. He can use buses, trains and undergrounds himself and does not need to be supported. He can speak and engage with people on the way and can manage diversions in the underground.
Which of these describes how well the claimant can plan and follow journeys?	(11a) Can plan and follow the route of a journey unaided
What is the reason for this answer?	PIP2 - reports no issues. HOC shows that he takes no medication for this mental health, is under GP care and there are no further plans for treatment. There is no formal diagnosis of Autism and although he had support at school, this was for his dyslexia. SOH shows that he has been working in responsible roles within blue chip companies. Although he lost his job in December 2023, he did not have any occupational health input prior to this. He uses public transport and walks places. As he is not working he stays at home more but is he has to go out anywhere

	he will use the underground and buses or walks places. There was no evidence in his MSE to show any restriction from a mental health, communication or cognitive perspective. There is no other evidence to support restriction. This is overall consistent with the lack of restriction indicated on the FH and in the questionnaire. It is likely that he can plan and follow the route of a journey unaided, on the majority of days, ensuring safety, timeliness, that it is done to an acceptable standard and repeatedly

Moving around

Functional history for moving around	He will go for walks 2 days a week lasting 20-60 minutes at a time. He does this without needing to stop. On the other days will use the cross trainer for 30-45 minutes at the gym 3 times a week (these are variable intensity workouts - ramping up to high intensities). This is a 10 minute walk each way week to the gym and then returning from the gym. He can do this without needing to rest. He uses no aids and states that he tends to walk at an above average pace.
Which of these describes how well the claimant can move around?	(12a) Can stand and then move more than 200 metres, either aided or unaided
What is the reason for this answer?	PIP2 - reports no issues. PIP2 - Reports issues with muscle flinching in his right arm. HOC shows that he is under GP care for his back and fibromyalgia, having just been referred to pain clinic. MT shows that he takes no prescribed pain relief and only OTC anti inflammatory pain and as required mild pain relief. HOC shows that he has sleep apnoea and whilst he reports fatigue as an issue, he is only needing to take

a 20 minute nap in the day normally to feel refreshed. SOH shows that he likes to exercise and go for walks. It also shows that is doing housework, is looking for work and was working full time until 4 months ago having lost his job due to his performance and he did not have any occupational health input.

IOs showed no that he did not appear fatigued or tired during the assessment. There was no expression of pain, breathlessness or wheeze.

There is no other evidence to support restriction.

This is consistent with the lack of reported restriction in the questionnaire and the ability reported in the FH.

It is likely that he can stand and then move more than 200 metres, either aided or unaided, on the majority of days, ensuring safety, timeliness, that it is done to an acceptable standard and repeatedly.

Physical health

Telephone assessment:

Mental state

Did not sound anxious during the assessment.
Did not require prompting.
Manner appeared normal and did not appear withdrawn. Mood appeared stable.
Had adequate rapport
Had adequate insight.
Had adequate memory.
Did cope with the assessment despite the prolonged length of it and being assessed alone.
Speech was normal in tone and content. Volume was normal and comprehensible.
No evidence of a cognitive impairment.
Engaged with the assessment process without any input.
(Telephone assessment undertaken)

Observations

The telephone assessment lasted 2 hours and 20 minutes. He did not appear fatigued or tired during the assessment.

There was no expression of pain, breathlessness or wheeze.

	He was communicative, was talkative, spoke in context, was easily understood, spoke at a normal rate and was able to understand the assessors questions.
Variability	See HOC.

Daily living qualifying period and prospective test

Has the claimant had the functional restriction for at least 3 months?	No daily living restriction found
Is the claimant likely to have the functional restriction in 9 months?	No daily living restriction found

Mobility qualifying period and prospective test

Has the claimant had the functional restriction for at least 3 months?	No mobility restriction found
Is the claimant likely to have the functional restriction in 9 months?	No mobility restriction found

Review period for PIP

When should this claim be reviewed?	Other Recommended review period: No further review required
Why do you recommend this review period?	His condition is causing no significant functional restriction at present and as such no review is recommended. It is likely that the functional restriction identified in

	this report will be present at the recommended point of review: Yes/No/Not Applicable Although they have not claimed under the special rules end of life provisions, in my opinion they do not meet the prescribed definition. There is no harmful information included in this report.
Is the claimant likely to need additional support for future claim processes?	No