PSYCHIATRIC MEDICAL SOURCE STATEMENT

NAME OF PATIENT: _____
SSN: _____
DATE: _____

Dear Doctor:

Please answer each of the following questions about your patient. They concern your patient's application for Social Security Disability Benefits. This form will be used by the Social Security Administration in deciding whether your patient is disabled. Please make sure your comments are legible and complete. If a question is not applicable to your patient, please so indicate.

1. Give first and last dates of treatment, and the average frequency of treatments:

_____
_____
_____
_____

2. Diagnosis (DSM IV): _____

3. Provide results of a recent mental status exam and results of any other tests given:

_____
_____
_____
_____

4. Describe patient's treatment, response, and prognosis. Include medications prescribed and side effects: _____

_____
_____
_____
_____

5. Have any of your patient's conditions lasted or can any conditions be expected to last at least twelve months? Yes _____ No _____ If yes, please specify:

_____
_____
_____

6. Is your patient disabled? (i.e. unable to engage in any type of full time employment.)
Yes _____ No _____

A. If yes, date disability began? _____

In questions 7 and 8, the terms for describing degree of impairments are defined as follows: **None** – no impairment; **Mild** – impairment does not seriously affect ability to function; **Marked** - impairment seriously interferes with the ability to function independently, appropriately, and effectively; **Extreme** – more severe than "marked."

7. Does the patient's condition result in restrictions of activities of daily living? (Note: "Activities of Daily Living" includes adaptive activities such as cleaning, shopping, cooking, taking public transportation, paying bills, maintaining a residence, caring for personal hygiene, using telephone, etc.

Degree of impairment: None _____ Mild _____ Marked _____ Extreme _____

Please provide examples of any restrictions of activities:

_____

_____

_____

8. Does the patient's condition result in difficulties in maintaining social functioning? (Note: "Social Functioning" refers to the capacity to interact appropriately and communicate effectively with other individuals).

Degree of impairment: None _____ Mild _____ Marked _____ Extreme _____

Please provide examples of any difficulties in maintaining social functioning:

_____

_____

_____

9. Does the patient's condition result in deficiencies of concentration, persistence, or pace, resulting in frequent failure to complete tasks in a timely manner? Yes _____ No _____

Degree of impairment: None _____ Mild _____ Marked _____ Extreme _____

Please provide examples of any such deficiencies:

_____

_____

_____

10. What is the patient's GAF? _____

11. How many days a month would patient's mental condition cause them to be absent from work?

Signature _____ Address _____

Print Name _____ _____

MEDICAL ASSESSMENT OF ABILITY TO DO WORK-RELATED ACTIVITIES (MENTAL)

NAME OF INDIVIDUAL SOCIAL SECURITY NUMBER

To determine this individual's ability to do work related activities on a day-to-day basis in a regular work setting, please give us an assessment – BASED ON YOUR EXAMINATION – of how the individual's mental/emotional capabilities are affected by the impairment(s). Consider the medical history, the chronicity of findings (or lack thereof), and the expected duration of any work-related limitations, but not the individual's age, sex, or work experience.
For each activity shown below:

(1) Describe the individual's ability to perform the activity according to the following terms:
Unlimited or Very Good – Ability to function in this area is more than satisfactory.
Good – Ability to function in this area is limited but satisfactory.
Fair – Ability to function in this area is seriously limited, but not precluded.
Poor or None – No useful ability to function in this area.

(2) Identify the particular medical or clinical findings (i.e., mental status examination, behavior, intelligence Test results, symptoms) your assessment of any limitations.
IT IS IMPORTANT THAT YOU RELATE PARTICULAR MEDICAL FINDINGS TO ANY ASSESSED LIMITATION IN CAPACITY: THE USEFULNESS OF YOUR ASSESSMENT DEPENDS ON THE EXTENT TO WHICH YOU DO THIS.

MAKING OCCUPATIONAL ADJUSTMENTS

Check the blocks representing the individual's ability to adjust to a job and complete item # 9.

	Unlimited Very Good	Good	Fair	Poor or None
1. Follow Work Rules				
2. Relate to Co-Workers				
3. Deal with the Public				
4. Use Judgment				
5. Interact with Supervisor(s)				
6. Deal with Work Stresses				
7. Function Independently				
8. Maintain attention/concentration				

9. Describe any limitations and include the medical/clinical findings that support this assessment.