Washington State Department of Social & Health Services
Transforming lives

Psychological / Psychiatric Evaluation

- **This form must be typed or completed using word processing software in order to be eligible for reimbursement.**
- **Do not perform the interview or evaluation if the individual is intoxicated.**
- **Attach all testing documentation, including sub scores.**
- **A Mental Status Examination, following 13-865 Guidelines, must be attached.**

A. Client Information

CLIENT'S NAME	DATE OF BIRTH	CASE NUMBER

Impairment / symptoms claimed by client:

Records reviewed:

B. Authorization to Release Information

I authorize _____ to release the following information regarding my condition to the Department of
EXAMINING PROFESSIONAL'S NAME

Social and Health Services (DSHS). This release includes the contents of this evaluation as well as diagnostic testing or treatment information concerning mental health, alcohol or drug abuse, sickle cell disease and the results of sexually transmitted disease, including HIV/AIDS (Revised Code of Washington (RCW) 70.24.105) (42 CFR part 2).

☐ An authorization was obtained by a separate release of information consent form, DSHS 14-012.

CLIENT'S SIGNATURE	DATE

C. Clinical Interview

1. Psychosocial History:

2. Medical / Mental Health Treatment History:

3. Educational / Work History:

4. Substance Use and Chemical Dependency (include treatment history):

5. Activities of Daily Living (include a description of the client's activities on a typical day):

6. Other:

Barcode label

13865

D. Clinical Findings

1. List all mental health symptoms that affect the individual's ability to work:

SYMPTOM	DESCRIPTION (INCLUDE SEVERITY AND FREQUENCY)

E. Assessment / Diagnosis

1. List each applicable diagnosis from the current Diagnostic and Statistical Manual of Mental Disorders (DSM) and describe how it is supported by available objective evidence:

DIAGNOSIS	ONSET DATE

F. Medical Source Statement

Severity Ratings:

"None or Mild" means there is no significant limit on the ability to perform one or more basic work activity.

"Moderate" means there are significant limits on the ability to perform one or more basic work activity.

"Marked" means a very significant limitation on the ability to perform one or more basic work activity.

"Severe" means the inability to perform the particular activity in regular competitive employment or outside of a sheltered workshop.

Rate the following basic work activities based on the individual's ability to sustain the activity over a normal workday and workweek on an ongoing, appropriate, and independent basis.

1. Basic Work Activity:	Effect on ability to perform one or more Basic Work Activity: None or Mild	Moderate	Marked	Severe	Severity Indeterminate
a. Understand, remember, and persist in tasks by following very short and simple instructions	☐	☐	☐	☐	☐
b. Understand, remember, and persist in tasks by following detailed instructions	☐	☐	☐	☐	☐
c. Perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances without special supervision	☐	☐	☐	☐	☐
d. Learn new tasks	☐	☐	☐	☐	☐
e. Perform routine tasks without special supervision	☐	☐	☐	☐	☐
f. Adapt to changes in a routine work setting	☐	☐	☐	☐	☐
g. Make simple work-related decisions	☐	☐	☐	☐	☐
h. Be aware of normal hazards and take appropriate precautions	☐	☐	☐	☐	☐
i. Ask simple questions or request assistance	☐	☐	☐	☐	☐
j. Communicate and perform effectively in a work setting	☐	☐	☐	☐	☐
k. Maintain appropriate behavior in a work setting	☐	☐	☐	☐	☐
l. Complete a normal work day and work week without interruptions from psychologically based symptoms	☐	☐	☐	☐	☐
m. Set realistic goals and plan independently	☐	☐	☐	☐	☐
2. Rate the overall severity based on the combined impact of all diagnosed mental impairments. Overall Severity Rating	☐	☐	☐	☐	☐

G. Substance Abuse

1. Are the current impairments primarily the result of alcohol or drug use within the past 60 days? ☐ Yes ☐ No
2. Would the current impairments persist following 60 days of sobriety? ☐ Yes ☐ No If not, how would they change?
3. Is a chemical dependency assessment or treatment recommended? ☐ Yes ☐ No

H. Prognosis / Plan

1. **Duration** (length of time the individual will be impaired with available treatment): _____ months.
2. Is a protective payee recommended due to mismanagement of funds? ☐ Yes ☐ No
3. Would vocational training or services minimize or eliminate barriers to employment? ☐ Yes ☐ No
4. Additional treatment recommendations:

The information you provide may be released to the individual you evaluate and is subject to Washington State Public Disclosure laws.	
Return this report to:	NAME AND SPECIALTY OF EXAMINING PROFESSIONAL
	TELEPHONE NUMBER (INCLUDE AREA CODE)
	STREET ADDRESS
	CITY STATE ZIP CODE
EXAMINATION DATE	TESTING DATE (IF DIFFERENT FROM EXAMINATION DATE)
EXAMINING PROFESSIONAL'S SIGNATURE*/TITLE	DATE

Mental Status Exam

Part 1. Observation Detail	
CATEGORY	OBSERVATION DETAIL (COMPLETE FOR ALL CLIENTS)
A. Appearance	
B. Speech	
C. Attitude and Behavior	
D. Mood	
E. Affect	

Part 2. Additional Detail		
CATEGORY	WITHIN NORMAL LIMITS?	IF NOT WITHIN NORMAL LIMITS, PROVIDE OBSERVATION DETAIL
A. Thought Process and Content	☐ Yes ☐ No	
B. Orientation	☐ Yes ☐ No	
C. Perception	☐ Yes ☐ No	
D. Memory	☐ Yes ☐ No	
E. Fund of Knowledge	☐ Yes ☐ No	
F. Concentration	☐ Yes ☐ No	
G. Abstract Thought	☐ Yes ☐ No	
H. Insight and Judgment	☐ Yes ☐ No	