MEDICAL SOURCE STATEMENT

INTELLECTUAL DISORDERS

Instructions/ Disclosure: This form is intended to be completed by a treating health provider for the listed patient. If you are unable to provide an answer to a question, please mark "N/A" or leave it blank. Please note this information will only be used in strict confidence for evaluation of the Patient's claim for disability by the Social Security Administration and will not be used for any other purpose.

PATIENT INFORMATION

Last Name:	***First Name:***	***Date of Birth:***

PROVIDER & CLINIC INFORMATION

Provider Name:		***Area(s) of Practice:***
Clinic Name:		
Address:	***Office Number:***	***Fax Number:***
Date of Patient's First Exam:	***Date of Patient's Most Recent Exam:***	
Today's Date:		

Please complete the following questions based on your <u>professional judgement</u> regarding the patient's mental processing limitations related to their diagnosed intellectual disorder, and side effects from medications and treatment.

1. In the order of significance, please list any medical conditions the patient has been diagnosed with and the **severity** of each: (MILD, MODERATE, SEVERE)

2. Describe the treatment the patient has undergone including duration and frequency:

3. What medication(s) have been prescribed to the patient and what are the known or alleged side effects?

4. What is the patient's current prognosis?

5. Have the patient's cognitive impairments lasted or are expected to last 12 **consecutive** months? **Yes** ☐ **No** ☐

6. Does the patient have **significantly subaverage** general intellectual functioning evident in their cognitive inability to function at a level required to participate in standardized testing of intellectual functioning? **Yes** ☐ **No** ☐

7. Does the patient have significant deficits in **adaptive functioning** currently manifested by their **dependence upon others** for personal needs (for example, toileting, eating, dressing, or bathing)? **Yes** ☐ **No** ☐

8. Is there sufficient evidence concerning the patient's intellectual and adaptive functioning and related history that demonstrates the disorder began **prior to the age of 22**? **Yes** ☐ **No** ☐

10. What is the patient's **full scale** (or comparable) IQ score? _____ Date of test: _____
11. What is the patient's **verbal or performance** IQ score? _____ Date of test: _____

12. Please indicate the symptoms attributable to the patient's anxiety or compulsive disorder:

Symptom	**Mark if present**	**Briefly describe the symptom and severity**
Restlessness	☐	
Easily fatigued	☐	
Difficulty concentrating	☐	
Irritability	☐	
Sleep disturbance	☐	
Anxiety attacks	☐	
Fear of being in a crowd	☐	
Depression	☐	
Anxiety	☐	
Repetitive behaviors aimed at reducing anxiety	☐	

The following questions relate to impairments or limitations in the patient's mental functioning due to their diagnosed medical condition(s) along with any side effects from medications or treatment. Refer to the following definitions in marking your responses:

Mild:	There are limitations on ability to function, but they are mild or transient.
Moderate:	The ability to function in this area is less than marked but more than mild.
Marked:	The ability to function in this area is seriously limited.
Extreme:	The ability to function in this area is precluded.
No Limitation:	There is no evidence available to rate the ability to function in this area.

13. Limitations concerning the patient's **<u>Understanding and Memory</u>** as related to their:

Ability to remember locations and work-like procedures:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to understand and remember new information (i.e., short term memory):

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to understand and remember detailed instructions:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

For any limitations indicated as **MARKED or EXTREME**, please elaborate further

14. Limitations concerning the patient's **Sustained Concentration and Persistence** as related to their:

Ability to maintain attention and concentration for extended periods:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to maintain regular attendance at work on a full-time basis:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to sustain an ordinary routine without special supervision:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

For any limitations indicated as **MARKED or EXTREME**, please elaborate further:

15. Limitations concerning the patient's **Adaptability** as related to their:

Ability to respond appropriately and adapt to changes in the work setting:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to tolerate normal levels of stress:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to manage psychologically based symptoms (i.e., anxiety, depression, tearfulness):

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to work through and manage mental fatigue:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

For any limitations indicated as **MARKED or EXTREME**, please elaborate further:

16. Limitations concerning patient's **Social Interaction** as related to their:

Ability to interact appropriately with the general public:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to interact appropriately with other co-workers:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to interact appropriately with supervisors:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to maintain socially appropriate behavior:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

Ability to adhere to basic standards of neatness, cleanliness, and hygiene:

Mild Limitation	Moderate Limitation	Marked Limitation	Extreme Limitation	No Limitation
☐	☐	☐	☐	☐

For any limitations considered **MARKED or EXTREME**, please elaborate further:

17. What are some **Activities of Daily Living** that are being impacted by the patient's intellectual disorder?

18. Approximately what percent of time do you believe the patient would be **"off task"** over the course of an 8-hour workday?

10%	15%	20%	25%	Other
☐	☐	☐	☐	_____

19. Approximately how many days of work per month do you think the patient is likely to miss **due to their medical conditions** and treatment thereof? _____ **days per month**

20. In your opinion, do you believe the patient would be capable of working an unskilled job **full-time?**
Why or why not?

Provider's Name and Designation	*Provider's Specialty*
Provider Signature	*Date*

PRIVACY ACT NOTICE: *The information requested on this form will be used in deciding this patient's Social Security Disability Claim. Failure to complete this form may result in a delay in processing the claim. Information furnished on this form may be disclosed by the Social Security Administration to another person or governmental agency only with respect to Social Security programs and to comply with Federal laws requiring the exchange of information between Social Security and other agencies.*

TO RETURN THIS REPORT

Electronic preferred

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