MEDICAL SOURCE STATEMENT

PSYCHOLOGICAL

Instructions/ Disclosure: This form is intended to be completed by a psychiatrist, psychologist, or therapist that is treating at least one mental health disorder or condition of the patient. If a question does not apply to the patient or cannot be answered, please write "N/A" or leave blank. Please provide any additional information in any of the comments sections as may be appropriate.

PATIENT INFORMATION

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

PROVIDER 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 professional judgement regarding the patient's mental processing and cognitive limitations related to their diagnosed medical condition(s).

1. What are the patient's mental diagnoses and what is the level of severity of each?
[Please indicate if MILD, MODERATE, or SEVERE]

2. Describe clinical tests that have been administered that substantiates the diagnoses:

3. Please describe the onset of the patient's major psychological or cognitive impairments:

4. Describe the symptoms the patient has for each of the above stated diagnoses?

5. What medication(s) have been prescribed and what are the reported side effects?

PLEASE REFER TO THE FOLLOWING DEFINITIONS FOR QUESTIONS 6-9:

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

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

a) Ability to remember locations and work-like procedures:

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

b) Ability to understand and remember short and simple instructions:

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

c) Ability to understand and remember detailed instructions:

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

d) Short-term memory recall:

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

e) Executive function:

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

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

7. Limitations concerning patient's <u>Sustained Concentration and Persistence</u> as related to their:

a) Ability to maintain attention and concentration for extended periods:

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

b) Ability to maintain regular attendance at work and sustain an ordinary routine without special supervision:

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

c) Ability to work in coordination with others without being distracted:

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

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

8. Limitations concerning patient's <u>Social Interaction</u> as related to their:

a) Ability to interact appropriately with the general public:

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

b) Ability to interact appropriately with other co-workers:

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

c) Ability to interact appropriately with supervisors:

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

d) Ability to maintain socially appropriate behavior:

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

e) 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:

9. Limitations concerning patient's ability for <u>Adaptation</u> as related to their:

a) Ability to respond appropriately to changes in the work setting:

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

b) Ability to be aware of normal hazards and take appropriate precautions:

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

c) Ability to travel in unfamiliar places or use public transportation:

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

d) Ability to tolerate normal levels of stress:

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

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

10. Approximately what percent of time do you believe the patient would be "off task" (require unscheduled breaks) over an 8-hour workday?

10% _____ 15% _____ 20% _____ 25% _____ Other _____

If the patient is likely to be 'off-task' 15% or more of the time, please explain why:

11. How often would the patient need to miss work each month because of their mental impairment(s) or for treatment thereof?

_____ days per month

If the patient is likely to miss 2 or more days of work per month, please explain why:

12. In your opinion, do you think that the patient can work on a regular and sustained basis considering their mental impairment(s)? If not, please explain why.

_____ _____

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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