

MENTAL IMPAIRMENT REPORT

Take to your doctor or other health professional to complete

Name of Patient (Last , First, MI): _____

Soc. Sec. No. _____ Birth date _____

(1) Record of Hospitalization

***BEGIN WITH MOST RECENT PERIOD OF HOSPITALIZATION**

Date Admitted: _____ Name of Institution: _____

Date Discharged: _____ Diagnosis: _____

Date Admitted: _____ Name of Institution: _____

Date Discharged: _____ Diagnosis: _____

Date Admitted: _____ Name of Institution: _____

Date Discharged: _____ Diagnosis: _____

(2) Present Symptoms:

(3) Past history and Course of Illness:

(4) Current Mental Status.

Date of Latest Examination: _____ Date of Initial Visit: _____

Frequency of Visits: _____

Appearance (grooming, attitude and general behavior):

Mood (please describe):

Affect (general emotional state):

Thought Content and Processes (please describe thought patterns):

Speech (please describe speech and speech patterns):

Memory (please describe if abnormal):

Recent: _____

Remote: _____

Immediate Recall: _____

Orientation: _____

Calculation: _____

Judgement: _____

Hallucination, Delusions, etc., (please give frequency, intensity and duration):

Suicidal Ideations (if present, indicate severity):

(5) Statement of Ability to do Work-Related Mental Activities

<u>Ratings</u>	<u>Definitions</u>
None	No impairment
Mild slightly affects ability to function	Suspected impairment of slight importance which
Moderate ability to function	Impairment which affects, but does not preclude
Moderately Severe function	Impairment which seriously interferes with ability to
Severe	Extreme impairment of ability to function

A. UNDERSTANDING AND MEMORY
Rating

1. The ability to remember locations and work-like procedures.

Findings that Support

2. The ability to understand and remember very short and simple instructions.

3. The ability to understand and remember detailed instructions.

B. SUSTAINED CONCENTRATION
AND PERSISTENCE

4. The ability to carry out very short and simple instructions.

5. The ability to carry out detailed instructions.

Rating	Rating	Findings that Support
6. The ability to maintain attention and concentration for extended periods.	_____	_____
C. UNDERSTANDING AND MEMORY		
8. The ability to sustain an ordinary routine without supervision.	_____	_____
9. The ability to work in coordination with or proximity of others without being distracted by them.	_____	_____
10. The ability to make simple work-related decisions.	_____	_____
11. the ability to complete a normal work day and work week without interruption from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods.	_____	_____
D. SOCIAL INTERACTION		
12. The ability to interact appropriately with the general public.	_____	_____
13. The ability to ask simple questions or request assistance.	_____	_____
14. The ability to accept instructions and respond appropriately to criticism from supervisors.	_____	_____
15. The ability to get along with co-workers or peers without distracting them or exhibiting behavioral extremes.	_____	_____
16. The ability to maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness.	_____	_____

Rating	Rating	Findings that Support
E. ADAPTATION		
17. The ability to respond appropriately to changes in the work setting.	_____	_____
18. The ability to be aware of normal hazards and take appropriate precautions.	_____	_____
19. The ability to travel in unfamiliar places or use public transportation.	_____	_____
20. The ability to set realistic goals or make plans independently of others.	_____	_____

(6) Activities of Daily Living

Please describe any significant impairment due to a psychiatric illness in this person's ability to perform activities of daily living, such as cleaning, shopping, cooking, bill paying, using public transportation, etc.:

Findings that support your assessment:

(7) Diagnosis (use DSM classification), Prognosis and Expected Duration of any Work

(8) Patient's Ability to Manage Funds:

DIAGNOSES

AXIS I: _____

AXIS II: _____

AXIS III: _____

AXIS IV: _____

AXIS V: Current _____
Highest
past year _____

Name and address of evaluator and facility:

Evaluator signature: _____ Date: _____

Title: _____