Mental Health Medical Source Statement

Name of Patient:_____ SSN: XXX-XX-_____ DOB: _____

IMPORTANT: Please complete the following items based on your clinical evaluation of the claimant and other testing results.

1. DSM-5 Evaluation:

Diagnosis: _____

Psychosocial and Contextual Factors: _____

2. List prescribed medications: _____

3. Side effects of medications: _____

4. Please identify your patient's signs and symptoms:

- ☐ Pervasive loss of interest in almost all activities
- ☐ Decreased energy and fatigue
- ☐ Generalized persistent anxiety
- ☐ Emotional withdrawal or isolation
- ☐ Psychomotor agitation or retardation
- ☐ Difficulty thinking or concentrating
- ☐ Paranoid thinking or inappropriate suspiciousness
- ☐ Sleep disturbance
- ☐ Hyperactivity, distractibility
- ☐ Thoughts of suicide
- ☐ Hallucinations or delusions
- ☐ Mood disturbance
- ☐ Manic syndrome
- ☐ Substance dependence
- ☐ Loss of intellectual ability of 15 IQ points or more
- ☐ Memory impairment
- ☐ Recurrent, severe panic attacks (how often? _____)
- ☐ Other: _____

5. Will your patient sometimes need to take unscheduled breaks during a workday due to symptoms? ☐ Yes ☐ No

If yes, how often? _____. For how long? _____.

6. How much is your patient likely to be <u>"off task"</u>? That is, what percentage of a typical workday would your patient's symptoms likely be severe enough to interfere with <u>attention and concentration</u> needed to perform even simple work tasks?

☐ 0% ☐ 5% ☐ 10% ☐ 15% ☐ 20% ☐ 25% or more

7. To what degree can your patient tolerate work stress?

Incapable of even "low stress" work	Capable of low stress work
Capable of moderate stress – normal work	Capable of high stress work

8. On average, how often do you anticipate that your patient's impairments or treatment would cause your patient to be absent from work?

- ☐ Never
- ☐ About one day per month
- ☐ About two days per month
- ☐ About three days per month
- ☐ About four days per month
- ☐ More than four days per month

9. Has your patient's impairment lasted or can it be expected to last at least twelve months? ☐ Yes ☐ No

10. FUNCTIONAL LIMITATION	**<u>None-Mild</u>**	**<u>Moderate</u>**	**<u>Marked*</u>**	**<u>Extreme</u>**
A. Understand, remember, or apply information	☐	☐	☐	☐
B. Interact with others	☐	☐	☐	☐
C. Concentrate, persist, or maintain pace	☐	☐	☐	☐
D. Adapt or manage oneself	☐	☐	☐	☐

Signature of Physician: _____ Date: _____

Print Name of Physician: _____ Specialty: _____

***For purposes of quantifying the term "marked" it shall mean the individual is unable to function in that area for more than 1/3 of the work day**