MEDICAL SOURCE STATEMENT REGARDING THE NATURE AND SEVERITY OF MEDICAL IMPAIRMENT(S) WITH RESPECT TO WORK-RELATED MENTAL ACTIVITIES

NAME: _____

SSN: _____

DOB: _____

Please provide your opinion based on your professional judgment of how your patient's medical impairment(s) affect the ability to meet the following mental demands of work, ***independent of any effect from alcohol and/or illicit drug use.***

A. For each demand, please use the following definitions to identify the patient's ability:

Excellent…… Not limited or only mildly limited

Satisfactory……. Moderately limited, but sufficient for an 8-hour workday & 5-day work week

Markedly Limited…… Ability exists, but not sufficient to complete an 8-hour workday & work week

Severely Limited……. No useful ability

Demand	**Excellent**	**Satisfactory**	**Markedly Limited**	**Severely Limited**
Understand and remember short, simple instructions	☐	☐	☐	☐
Understand and remember detailed instructions	☐	☐	☐	☐
Maintain attention/concentration	☐	☐	☐	☐
Sustain an ordinary routine without special supervision	☐	☐	☐	☐
Work with or near others without being distracted	☐	☐	☐	☐
Make simple work-related decisions	☐	☐	☐	☐
Complete a normal workday or workweek	☐	☐	☐	☐
Deal with work stress	☐	☐	☐	☐
Interact appropriately with the public	☐	☐	☐	☐
Perform activities within a schedule	☐	☐	☐	☐
Fulfill quota or production requirements	☐	☐	☐	☐
Get along with co-workers and peers	☐	☐	☐	☐
Accept instructions/respond appropriately to criticism	☐	☐	☐	☐
Maintain socially appropriate behavior	☐	☐	☐	☐
Respond appropriately to changes in the work setting	☐	☐	☐	☐
Set realistic goals or make plans independently of others	☐	☐	☐	☐

B. DIAGNOSES: _____

SIGNS/FINDINGS:

___ feelings of hopelessness	___ flight of ideas	___ lack of insight
___ feelings of worthlessness	___ tearfulness	___ pressured speech
___ mood disturbance	___ social immaturity	___ agitation/irritability
___ feelings of helplessness	___ attention difficulty	___ anxiety
___ obsessive-compulsive behavior	___ poor judgment	___ memory difficulty
___ concentration difficulty	___ paucity of ideas	___ frustration
___ psychomotor retardation	___ decreased energy	___ low self-esteem
___ visual hallucinations	___ auditory hallucinations	___ appetite change
___ hypervigilance	___ motor tension	___ anhedonia
___ autonomic hyperactivity	___ vigilance and scanning	___ tangential thinking
___ sleep pattern changes	___ hyperactivity	___ inappropriateness
___ paranoia	___ delusional thoughts	___ intrusive memories

Other: _____

		Yes	**No**
C.	Does your patient's mental impairment(s) and symptoms distract the patient from successfully completing tasks in a timely manner consistently over the course of a full-time workday?	☐	☐
D.	Does your patient have a residual disease process of at least 2 years duration that has resulted in such a marginal adjustment that even a minimal increase in mental demands or change in environment would be predicted to cause the individual to decompensate?	☐	☐
E.	Does your patient have a current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement?	☐	☐
F.	On the average, do you believe your patient's impairment(s) or treatment(s) would cause them to be absent from work *more than* 2 times a month?	☐	☐
G.	Can the patient manage their benefits in their own best interest?	☐	☐
H.	Are the above impairments the result of mental illness and ***not*** due to drug or alcohol use?	☐	☐

I. The patient's impairments have existed and persisted as outlined above since at least _____

J. Additional Remarks (include any medications you are prescribing):

_____

_____

_____

_____ _____ _____

Clinician Signature Clinician Name Date of Evaluation