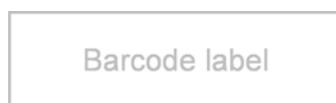


Psychological / Psychiatric Evaluation

- This form must be typed or completed using word processing software in order to be eligible for reimbursement.
- Do not perform the interview or evaluation if the individual is intoxicated.
- Attach all testing documentation, including sub scores.
- A Mental Status Examination, following 13-865 Guidelines, must be attached.

A. Client Information		
CLIENT'S NAME	DATE OF BIRTH	CASE NUMBER
Impairment / symptoms claimed by client:		
Records reviewed:		
B. Authorization to Release Information		
<p>I authorize _____ to release the following information regarding my condition to the Department of EXAMINING PROFESSIONAL'S NAME</p> <p>Social and Health Services (DSHS). This release includes the contents of this evaluation as well as diagnostic testing or treatment information concerning mental health, alcohol or drug abuse, sickle cell disease and the results of sexually transmitted disease, including HIV/AIDS (Revised Code of Washington (RCW) 70.24.105) (42 CFR part 2).</p> <p><input type="checkbox"/> An authorization was obtained by a separate release of information consent form, DSHS 14-012.</p>		
CLIENT'S SIGNATURE		DATE
C. Clinical Interview		
1. Psychosocial History:		
2. Medical / Mental Health Treatment History:		
3. Educational / Work History:		
4. Substance Use and Chemical Dependency (include treatment history):		
5. Activities of Daily Living (include a description of the client's activities on a typical day):		
6. Other:		



D. Clinical Findings

1. List all mental health symptoms that affect the individual's ability to work:

SYMPTOM	DESCRIPTION (INCLUDE SEVERITY AND FREQUENCY)

E. Assessment / Diagnosis

1. List each applicable diagnosis from the current Diagnostic and Statistical Manual of Mental Disorders (DSM) and describe how it is supported by available objective evidence:

DIAGNOSIS	ONSET DATE

F. Medical Source Statement

Severity Ratings:

“None or Mild” means there is no significant limit on the ability to perform one or more basic work activity.

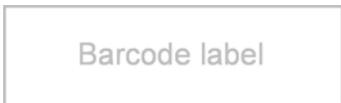
“Moderate” means there are significant limits on the ability to perform one or more basic work activity.

“Marked” means a very significant limitation on the ability to perform one or more basic work activity.

“Severe” means the inability to perform the particular activity in regular competitive employment or outside of a sheltered workshop.

Rate the following basic work activities based on the individual's ability to sustain the activity over a normal workday and workweek on an ongoing, appropriate, and independent basis.

1. Basic Work Activity:	Effect on ability to perform one or more Basic Work Activity:				
	<u>None or Mild</u>	<u>Moderate</u>	<u>Marked</u>	<u>Severe</u>	<u>Severity Indeterminate</u>
a. Understand, remember, and persist in tasks by following very short and simple instructions.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Understand, remember, and persist in tasks by following detailed instructions.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances without special supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Learn new tasks.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Perform routine tasks without special supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Adapt to changes in a routine work setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Make simple work-related decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Be aware of normal hazards and take appropriate precautions.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Ask simple questions or request assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Communicate and perform effectively in a work setting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Maintain appropriate behavior in a work setting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Complete a normal work day and work week without interruptions from psychologically based symptoms.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Set realistic goals and plan independently.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Rate the overall severity based on the combined impact of all diagnosed mental impairments.					
Overall Severity Rating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



G. Substance Abuse

1. Are the current impairments primarily the result of alcohol or drug use within the past 60 days? Yes No
2. Would the current impairments persist following 60 days of sobriety? Yes No If not, how would they change?
3. Is a chemical dependency assessment or treatment recommended? Yes No

H. Prognosis / Plan

1. **Duration** (length of time the individual will be impaired with available treatment): _____ months.
2. Is a protective payee recommended due to mismanagement of funds? Yes No
3. Would vocational training or services minimize or eliminate barriers to employment? Yes No
4. Additional treatment recommendations:

The information you provide may be released to the individual you evaluate and is subject to Washington State Public Disclosure laws.

Return this report to:	NAME AND SPECIALTY OF EXAMINING PROFESSIONAL
	TELEPHONE NUMBER (INCLUDE AREA CODE)
	STREET ADDRESS
	CITY STATE ZIP CODE
EXAMINATION DATE	TESTING DATE (IF DIFFERENT FROM EXAMINATION DATE)
EXAMINING PROFESSIONAL'S SIGNATURE*/TITLE	DATE

Mental Status Exam

Part 1. Observation Detail: Complete each category below for all clients.

A. Appearance:

B. Speech:

C. Attitude and Behavior:

D. Mood:

E. Affect:

Part 2. Additional Detail: If not within normal limits in each category below, provide observation detail.

A. Thought Process and Content; within normal limits? Yes No; if no, provide detail below:

B. Orientation; within normal limits? Yes No; if no, provide detail below:

C. Perception; within normal limits? Yes No; if no, provide detail below:

D. Memory; within normal limits? Yes No; if no, provide detail below:

E. Fund of Knowledge; within normal limits? Yes No; if no, provide detail below:

F. Concentration; within normal limits? Yes No; if no, provide detail below:

G. Abstract Thought; within normal limits? Yes No; if no, provide detail below:

H. Insight and Judgment; within normal limits? Yes No; if no, provide detail below:

