

CLIENT'S NAME	DATE OF BIRTH	CLIENT ID
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Psychological / Psychiatric Evaluation

- This form must be typed or completed using word processing software in order to be eligible for reimbursement.
- Attach all testing documentation, including sub scores.
- A Mental Status Examination, following 13-865 Guidelines, must be attached.
- Please ensure you are using the current version of the form, located [here](#).

A. Client Information

Impairment / symptoms claimed by client:

Records review ed:

B. Authorization to Release Information

I authorize _____ to release the follow ing information regarding my condition to the Department of EXAMINING PROFESSIONAL'S NAME 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 use, sickle cell disease, and sexually transmitted disease, including HIV/AIDS (Chapter 70.02 Revised Code of Washington (RCW)) (42 Code of Federal Regulations (CFR) part 2).

An authorization was obtained by a separate release of information consent form, DSHS 14-012.

CLIENT'S SIGNATURE	DATE
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C. Clinical Interview

1. Psychosocial History:

2. Medical / Mental Health Treatment History:

3. Educational / Work History:

4. Substance Use History (include any current substance use disorder diagnosis and related symptoms in Sections D and E):

5. Instrumental Activities of Daily Living (include a description of the client's activities and routines on a typical day):

6. Other:

D. Clinical Findings

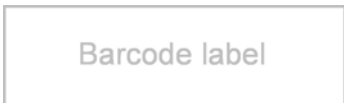
1. List all mental health symptoms that affect the individual's ability to work:

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 no significant limitation on the ability to perform the activity.

“Moderate” means a significant limitation on the ability to perform the activity.

“Marked” means a very significant limitation on the ability to perform the activity.

“Severe” means the inability to perform the 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 work week on an ongoing, appropriate, and independent basis.

1. Basic Work Activity:	Severity:				
	None or Mild	Moderate	Marked	Severe	Severity Indeterminate
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

G. Substance Use

- Are the effects on basic work activities primarily the result of a substance use disorder? Yes No Please explain.
- Would the effects on basic work activities persist following 60 days of sobriety? Yes No If no, how would they change?
- Is a chemical dependency assessment or substance use treatment recommended? Yes No

H. Prognosis / Plan

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