CLIENT'S NAME	DATE OF BIRTH	CLIENT ID

Washington State Department of Social & Health Services
Transforming lives

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 reviewed:

B. Authorization to Release Information

I authorize _____ to release the following 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

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

Barcode label

13865

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 workweek 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	☐	☐	☐	☐	☐
b. Understand, remember, and persist in tasks by following detailed instructions	☐	☐	☐	☐	☐
c. Perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances without special supervision	☐	☐	☐	☐	☐
d. Learn new tasks	☐	☐	☐	☐	☐
e. Perform routine tasks without special supervision	☐	☐	☐	☐	☐
f. Adapt to changes in a routine work setting	☐	☐	☐	☐	☐
g. Make simple work-related decisions	☐	☐	☐	☐	☐
h. Be aware of normal hazards and take appropriate precautions	☐	☐	☐	☐	☐
i. Ask simple questions or request assistance	☐	☐	☐	☐	☐
j. Communicate and perform effectively in a work setting	☐	☐	☐	☐	☐
k. Maintain appropriate behavior in a work setting	☐	☐	☐	☐	☐
l. Complete a normal work day and work week without interruptions from psychologically based symptoms	☐	☐	☐	☐	☐
m. Set realistic goals and plan independently	☐	☐	☐	☐	☐

2. Rate the overall severity based on the combined impact of all diagnosed mental impairments.

Overall Severity Rating	☐	☐	☐	☐	☐

G. Substance Use

1. Are the effects on basic work activities primarily the result of a substance use disorder? ☐ Yes ☐ No Please explain.

2. Would the effects on basic work activities persist following 60 days of sobriety? ☐ Yes ☐ No If no, how would they change?

3. Is a chemical dependency assessment or substance use 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 ☐ Partially Please explain.

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: