srs 1/01

MEDICAL REPORT FOR CLAIM OF EXEMPTION FROM WORK PROGRAM DUE TO MENTAL IMPAIRMENT

Patient's Name: ______________________________

Social Security No.: ______________________________

1. Give first and last dates of treatment and the average frequency of treatment.

2. Diagnoses (please give DSM IV classification, including five axes).

    AXIS I: ______________________________

    AXIS II: ______________________________

    AXIS III: ______________________________

    AXIS IV: ______________________________

    AXIS V: ______________________________

3. Describe in detail the patient's symptoms.

4. Describe in detail the patient's signs (clinical findings) including mental status examination and, if relevant, content of delusions, hallucinations, ideas of references, etc. Please include any tests administered, dates and results.

5. a. Can the patient's mental disorder be expected to last at least 3 months? Yes ❒ No ❒

b. Can the patient's mental disorder be expected to last at least 12 months? Yes ❒ No ❒

6. a. Describe course of treatment, including medications and dosage.

b. Does your patient suffer side effects from the prescribed medications? Yes ❒ No ❒
If yes, please describe.

7. Please indicate whether your patient can perform the following work activities:

		Yes	**No**	**Limited Ability**
A.	Understand, remember & carry out instructions.	❒	❒	❒
B.	Respond appropriately to supervision.	❒	❒	❒
C.	Respond appropriately to co-workers.	❒	❒	❒
D.	Meet normal quality, production and attendance standards.	❒	❒	❒
E.	Respond to customary work pressures.	❒	❒	❒
F.	Perform complex tasks on a sustained basis in a full-time work setting.	❒	❒	❒
G.	Perform simple tasks on a sustained basis in a full-time work setting.	❒	❒	❒
H.	Make simple work-related decisions.	❒	❒	❒
I.	Travel in unfamiliar places or use public transportation.	❒	❒	❒

8. Please state whether mandatory work activity requiring regular and punctual attendance is consistent with your *current* treatment plan for this patient. Yes ❐ No ❐

9. Additional comments:

Date: ________________

Signature: ______________________________

[Print name]: ______________________________

Specialty/ title: ______________________________

License no.: ______________________________

Address: ______________________________

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Telephone No. ______________________________