City of Escanaba
PO Box 948 • 410 Ludington St • Escanaba, MI 49829-0948
(906)786.0605
www.escanaba.org

Psychiatric Medical Report

Retain a copy for your records

Please **PRINT** or **TYPE**.

NOTE: This form is to be completed and signed by a licensed psychologist or psychiatrist.

This report must confirm the diagnosis and severity of the impairment for reviewers who may not see the patient. Accurate and complete information is crucial to the disability decision. A psychiatric *disability* examination and report differs in content from the usual psychiatric examination and report used for diagnostic and *treatment* purposes. The disability report requires objective clinical evidence, including complete mental status observations. Opinions must be supported by specific clinical observations. The diagnosis should be determined by the clinical findings as observed during the examination and substantiated in this report rather than on history or undocumented conclusions.

1. Patient information

Last name*	First name*	Last four digits of SSN*	Phone number (with area code)*

Mailing address*

City*	State*	Zip code*

Email address

Name of employer*	Employer number

2. Complaints and Symptoms

Obtain from claimant and/or third party. Discuss any discrepancies between patient's statements and that of third party. Please identify relationship of third party.

HISTORY OF ILLNESS

Approximate date illness began Has illness caused weight gain/loss? ☐ Yes ☐ No Has illness caused insomnia? ☐ Yes ☐ No

Describe any personality change, mood swings, etc.

Describe effect of illness on work.

Describe any further characteristics of illness.

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MEDICATIONS	List treatment/medications: Treating sources (i.e. physicians, hospitals, clinics), medications prescribed, compliance, any side effects, response to all treatment.
PERSONAL HISTORY	Describe how childhood, school, marriage, work, illness, alcohol, prison, etc. have impacted patient's current condition.

3. Daily Functioning

To be completed by physician based on examination of claimant and/or interviewing a third party. If a third party accompanies patient to the examination, indicated who provided the information. Also discuss any discrepancy between patient's statements and that of third party. Comment on patient's ability to function independently and appropriately and whether the activity can be maintained on a sustained basis. Describe any examples observed.

SOCIAL	How does patient get along with and communicate with family members, neighbors, co-workers, employees? Describe any special considerations given. How did patient relate to you and your staff:
INTERESTS	Describe patient's interests. How has the illness affected their interests? Are interests realistic, grandiose, or manifestations of a delusional system?
ACTIVITIES	Describe patient's typical day – Shopping, house/car repairs, church, household chores, work, recreation. Consider frequency, independence, appropriateness, sustainability, and effectiveness of these activities during the course of the illness. How effectively does the patient care for basic needs of food, clothing, shelter? Does someone else provide these basic needs?

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OBSERVATIONS

Give details of visit. Was patient alone or accompanied? Describe height/weight, gait, posture, manners, clothing, hygiene, punctuality, memory. Explain any assistance required in preparing for appointment (bathing, dressing, etc.).

ATTITUDE-BEHAVIOR

Describe patient's contact with reality, self-esteem, motor activity, hyperactivity, retardation, degree of autonomy/dependence, motivation, insight, tendency to exaggerate/minimize symptoms. Was patient relaxed, pleasant, unusual in any way?

MENTAL ACTIVITY

Consider speech and mark all that apply:

❒ Spontaneous ❒ Pressured ❒ Blocked ❒ Slow ❒ Illogical ❒ Well organized ❒ Vague ❒ Circumstantial

Explain any boxes checked above. Give examples of mental activity.

EMOTIONAL REACTION

Consider emotional state and mark all that apply:

❒ Depressed ❒ Fearful ❒ Elated ❒ Flat ❒ Angry ❒ Blunt ❒ Suspicious ❒ Friendly

Explain any boxes checked above. Describe emotional reaction to visit.

MENTAL TREND

Consider trends and content of thought. Mark all that apply:

❒ Hallucinations ❒ Suicidal thoughts ❒ Delusions ❒ Unusual Powers ❒ Persecutions ❒ Worthlessness

❒ Obsessions ❒ Sleep Disorders ❒ Thoughts controlled by others

Explain any boxes checked above. Describe emotional reaction to visit.

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4. Psychiatric Capabilities

	Level of Impairment	Explanation *(all must be addressed)*
Ability to comprehend and follow instructions	❒ None ❒ Slight ❒ Moderate ❒ Marked	
Ability to perform simple and repetitive tasks	❒ None ❒ Slight ❒ Moderate ❒ Marked	
Ability to maintain work pace appropriate to a given workload	❒ None ❒ Slight ❒ Moderate ❒ Marked	
Ability to perform complex or varied tasks	❒ None ❒ Slight ❒ Moderate ❒ Marked	
Ability to relate to other people beyond giving and receiving instructions	❒ None ❒ Slight ❒ Moderate ❒ Marked	
Ability to influence people	❒ None ❒ Slight ❒ Moderate ❒ Marked	
Ability to make generalizations, evaluations, or decisions without immediate supervision	❒ None ❒ Slight ❒ Moderate ❒ Marked	
Ability to to accept and carry out responsibility for direction, control, and planning	❒ None ❒ Slight ❒ Moderate ❒ Marked	

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5. Diagnosis

DSM-IV (or current DSM) definitions, in numerical form, must be included with the diagnosis.

AXIS I

AXIS II

AXIS III

AXIS IV

AXIS V

6. Disability Opinion

1. Is the person disabled from performing their job? ☐ Yes ☐ No
2. Is the disability ☐ temporary or ☐ permanent?
3. Was the person's performance of job duties the proximate cause of their disability? ☐ Yes ☐ No
4. Has the person exhausted reasonable treatment options? ☐ Yes ☐ No

Additional comments may be attached as needed.

7. Physician's signature

Physician's name (print or type)*		Date patient first seen*	Date patient last seen*
Physician's mailing address*			Phone number (with area code)*
Physician's city*	State*	Zip*	Specialty*
Signature of physician*			Date (mm/dd/yyyy)*

Data collected on this form will be used by The City staff for identification and documentation only.

* Required field

Please mail completed form to:

City of Escanaba
Controller's Office
PO Box 948
410 Ludington St
Escanaba, MI 49829-0948