MENTAL MEDICAL SOURCE STATEMENT – SHORT FORM

Patient Name:_____

Provider Name:_____

Diagnoses:_____

First Date You Saw Patient: _____
Frequency of Treatment_____

OPINION OF PATIENT'S CAPACITY TO PERFORM WORK ACTIVITIES

Please provide your opinion as to your patient's ability to perform work activities in an 8-hour workday:

1. PATIENT'S ABILITY TO PERFORM TASKS:

   A. Can patient perform detailed/complex tasks (such as in skilled jobs) or only simple, unskilled tasks (circle one)?

      DETAILED/COMPLEX SIMPLE UNABLE TO WORK

   B. Can patient remain on-task for an 8-hour workday ? YES NO

   C. If not, what amount of time or percentage of the day will they be off-task due to their mental health symptoms?

      _____

   D. How many days per month will patient be absent from work due to mental health symptoms?

      0 days 1 day 2 days 3 days 4 days+

2. INTERACTION W/ THE PUBLIC, COWORKERS & SUPERVISORS – how much interaction in the workplace can patient tolerate for <u>each group</u>?
   Please Answer: **Constant** = all day; **Frequent** = 2/3 of the day;
   Occasional = 1/3 of the day; or **None**.

   PUBLIC_____ COWORKERS_____ SUPERVISORS_____

3. WHAT IS THE EARLIEST DATE THAT THE ABOVE LIMITATIONS BEGAN: _____.

4. Briefly, what medical conditions/symptoms does patient have that support your answers above?
   _____
   _____
   ____

_____ _____

Signature Date