SCHIZOPHRENIA, PARANOID AND OTHER PSYCHOTIC MENTAL DISORDERS PROFESSONAL SOURCE DATA SHEET

Short form

FOR REPRESENTATIVE USE ONLY

REPRESENTATIVE'S NAME AND ADDRESS

REPRESENTATIVE'S TELEPHONE

REPRESENTATIVE'S EMAIL

PROFESSIONAL SOURCE NAME AND ADDRESS

PROFESSIONAL SOURCE TELEPHONE

PROFESSIONAL SOURCE EMAIL

PATIENT'S NAME AND ADDRESS

PATIENT'S TELEPHONE

PATIENT'S EMAIL

PATIENT'S SSN

TYPE OF CLAIM:

Title 2 ☐ DIB/DWB ☐ CDB

Title 16 ☐ DI ☐ DC

LEVEL OF ADJUDICATION:

Initial DDS ☐ Recon DDS ☐

Initial CDR ☐ Hearing Officer ☐

Administrative Law Judge ☐ Appeals Council ☐

Federal District Court ☐ Federal Appeals Court ☐

Dear Dr.

We are pursuing the Social Security disability claim for the above-named individual (the "patient"). We understand how valuable your time is, and this data sheet has been designed to allow you to provide medical information in an efficient and organized way. As a treating physician, your records and medical judgment are vital in arguing for a fair disability determination for the patient before the Social Security Administration (SSA). If you receive multiple data sheets, please disregard repetitive questions.

Your medical or other specialty please:

Note 1: This document may not have legal validity for Social Security disability determination purposes unless completed by a licensed M.D. or D.O., preferably a psychiatrist. A licensed Ph.D.-level clinical psychologist experienced in the evaluation of psychotic disorders may also complete parts of this form not concerning medical diagnosis of any brain or other physical disorder, medication, physical examination findings, or interpretation of any medical test (including neuroimaging).

Note 2: This document only concerns psychotic mental disorders. Other impairments and limitations resulting from a combination of impairments should be considered separately.

Note 3: Age, degree of general physical conditioning, sex, body habitus (i.e., natural body build, physique, constitution, size, and weight), insofar as they are unrelated to the patient's medical disorder and symptoms, should not be considered when assessing the functional severity of the impairment.

I. Does the patient have a psychotic mental disorder?

☐ **Yes** ☐ **No**

If **Yes**, please specify the diagnosis, or check **Unknown**.

☐ **Unknown**

II. When did the patient first complain to you of symptoms consistent with a psychotic mental disorder?

Date:

III. Is the patient currently abusing alcohol or other drugs?

☐ **Yes** ☐ **No** ☐ **Unknown**

IV. Treatment

(Please include medications and side-effects experienced.)

V. Which of the following clinical abnormalities are persistently present, either continuously or intermittently?

A. ☐ Delusions or hallucinations

B. ☐ Catatonic or other grossly disorganized behavior

C. ☐ Incoherence ☐ Loosening of associations
☐ Illogical thinking ☐ Poverty of content of speech

1. ☐ Blunt affect

2. ☐ Flat affect

3. ☐ Inappropriate affect

D. ☐ Emotional withdrawal and/or isolation

VI. Does the patient have any of the following current marked limitations?

A. ☐ Marked restriction of activities of daily living

B. ☐ Marked difficulties in maintaining social functioning

C. ☐ Marked difficulties in maintaining concentration, persistence, or pace

D. ☐ Repeated episodes of decompensation, each of extended duration

VII. Does the patient have a history of a chronic schizophrenic, paranoid, or other psychotic disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, but with symptoms or signs currently attenuated by medication or psychosocial support?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, indicate any of the following that apply.

A. ☐ Repeated episodes of decompensation, each of extended duration.

B. ☐ A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate.

C. ☐ Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

VIII. For children under age 18 only.

Does the child have significant limitations in age-appropriate activities?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, specify the age-appropriate limitations of which you are aware, citing specific developmental test results where possible.

A. For older infants and toddlers (age 1 to attainment of age 3)

1. ☐ Gross or fine motor development at a level generally acquired by children no more than one-half the child's chronological age

2. ☐ Cognitive/communicative function at a level generally acquired by children no more than one-half the child's chronological age

3. ☐ Social function at a level generally acquired by children no more than one-half the child's chronological age

4. ☐ Attainment of development or function generally acquired by children no more than two-thirds of the child's chronological age in two or more areas covered by **1**, **2**, or **3**

B. For children (age 3 to attainment of age 18)

1. ☐ Marked impairment in age-appropriate cognitive/communicative function

2. ☐ Marked impairment in age-appropriate social functioning

3. ☐ Marked impairment in age-appropriate personal functioning

4. ☐ Marked difficulties in maintaining concentration, persistence, or pace

IX. Specific residual functional capacities and limitations

Note: The following questions apply only to patients at least 18 years of age. Please assess each mental activity within the context of the patient's ability to sustain that activity over a normal workday and workweek, on an ongoing basis.

	Not Significantly Limited	Moderately Limited	Markedly Limited	Unknown
A. Understanding and Memory	1. ☐	2. ☐	3. ☐	4. ☐
1. Ability to remember locations and work-like procedures.	1. ☐	2. ☐	3. ☐	4. ☐
2. Ability to understand and remember very short and simple instructions.	1. ☐	2. ☐	3. ☐	4. ☐
3. Ability to understand and remember detailed instructions.	1. ☐	2. ☐	3. ☐	4. ☐
B. Sustained Concentration and Persistence	1. ☐	2. ☐	3. ☐	4. ☐
1. Ability to carry out very short and simple instructions.	1. ☐	2. ☐	3. ☐	4. ☐
2. Ability to carry out detailed instructions.	1. ☐	2. ☐	3. ☐	4. ☐
3. Ability to maintain attention and concentration for extended periods.	1. ☐	2. ☐	3. ☐	4. ☐
4. Ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances.	1. ☐	2. ☐	3. ☐	4. ☐
5. Ability to sustain an ordinary routine without special supervision.	1. ☐	2. ☐	3. ☐	4. ☐
6. Ability to work in coordination with or proximity to others without being distracted by them.	1. ☐	2. ☐	3. ☐	4. ☐
7. Ability to make simple work-related decisions.	1. ☐	2. ☐	3. ☐	4. ☐
8. Ability to complete a normal workday and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods.	1. ☐	2. ☐	3. ☐	4. ☐
C. Social Interaction	1. ☐	2. ☐	3. ☐	4. ☐
1. Ability to interact appropriately with the general public.	1. ☐	2. ☐	3. ☐	4. ☐
2. Ability to ask simple questions or request assistance.	1. ☐	2. ☐	3. ☐	4. ☐
3. Ability to accept instructions and respond appropriately to criticism from supervisors.	1. ☐	2. ☐	3. ☐	4. ☐
4. Ability to get along with coworkers or peers without distracting them or exhibiting behavioral extremes.	1. ☐	2. ☐	3. ☐	4. ☐
5. Ability to maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness.	1. ☐	2. ☐	3. ☐	4. ☐

D. ADAPTATION	1. ☐	2. ☐	3. ☐	4. ☐
1. Ability to respond appropriately to changes in the work setting.	1. ☐	2. ☐	3. ☐	4. ☐
2. Ability to be aware of normal hazards and take appropriate precautions.	1. ☐	2. ☐	3. ☐	4. ☐
3. Ability to travel in unfamiliar places or use public transportation.	1. ☐	2. ☐	3. ☐	4. ☐
4. Ability to set realistic goals or make plans independently of others.	1. ☐	2. ☐	3. ☐	4. ☐

(Use this space for discussion of evidence associated with residual functional capacity assessment.)

X. Additional Physician/Psychologist Comments

Physician or Psychologist Name (print or type)

Physician or Psychologist Signature (no name stamps)

Date