REPORT ON INDIVIDUAL WITH MENTAL IMPAIRMENT

The patient named on the attached form has applied for a determination of disability under the Social Security Act. We would appreciate receiving a report describing the patient's condition. In evaluating a mental impairment, we need to know:

(1) THE DATE OF ONSET AND COURSE OF THE CONDITION - Including earlier periods of hospitalization, behavior prior to admission, etc.

(2) YOUR FINDINGS - Adjustment while institutionalized, psychiatric and physical findings, diagnosis, therapy and response.

(3) PRESENT CONDITION AND PROGNOSIS - Including plans for release.

(4) POST HOSPITALIZATION FOLLOW-UP - Medications, dosage and recommendations for any other treatment methods prescribed.

Much of this information should be available in your records, in the staff summary or clinical abstract. A copy of this summary, updated by a brief description of the patient's current condition, activities, and plans for release will usually provide the information we need.

Note: If this patient is not currently institutionalized, or is on leave, please report on the patient's condition during his or her period of hospitalization. In such cases, we would appreciate a copy of the discharge summary, available social service reports and information about any treatment subsequent to release.

If you are furnishing a discharge summary, only questions 7 and 8 and the signature block of this form need to be completed. If you are not able to furnish a summary, you may report by completing all items on the form.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 36 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO THE OFFICE THAT REQUESTED IT. If you do not know the address, you may call Social Security at 1-800-772-1213.** *You may send comments on our time estimate above to:* ***SSA, 6401 Security Boulevard, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.***

Form Approved
OMB No. 0960-0058

REPORT ON INDIVIDUAL WITH MENTAL IMPAIRMENT

PRIVACY ACT NOTICE: The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) and 1631(e)(1) of the Social Security Act. The information on this form is needed by Social Security to complete processing of the named patient's claim. While giving us the information on this form is voluntary, failure to provide the requested information may prevent an accurate or timely decision on the named patient's claim. Although the information you furnish on this form is almost never used for any purpose other than making a determination about disability, such information may be disclosed by the Social Security Administration to another person or governmental agency only with respect to Social Security programs and to comply with federal laws requiring the exchange of information between Social Security and another agency. We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security Offices. If you want to learn more about this, contact any Social Security Office.

(1) IDENTIFYING INFORMATION (to be completed by Requesting Office)

PATIENT'S NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER – –
WAGE EARNER'S NAME (If different from patient)		ADDRESS OF REQUESTING OFFICE
WAGE EARNER'S SOCIAL SECURITY NUMBER – –		

(2) RECORD OF HOSPITAL-IZATION

CURRENT PERIOD OF HOSPITAL-IZATION

Date Admitted _____

☐ Committed-Medical Certificate

☐ Committed-Court

☐ Voluntary Admission

Give dates of trial visits *(If None, please indicate)*

From:
TO:

From:
TO:

If PATIENT IS ON LEAVE OR HAS BEEN DISCHARGED, furnish a copy of the discharge summary or social service report and show current address here:

PRIOR PERIODS OF HOSPITAL-IZATION

Admission Date	Name of Institution	Discharge Date

(3) PAST HISTORY AND CONDITION ON ADMISSION

COPIES OF YOUR RECORDS *(staff summaries or case notes)* MAY BE FURNISHED IN LIEU OF STATEMENTS

(4) FINDINGS

(Describe findings (orientation, coherence, emotional status, etc.) with ONSET dates. Furnish copies (or results) of psychological tests and describe any physical impairments)

(5) DIAGNOSIS	Use APA Classification.
(6) COURSE OF ILLNESS DURING HOSPITAL-IZATION **(Please complete if patient is not presently hospitalized)**	MOST CURRENT STATUS - Memory, Reasoning, Mood, etc. - THERAPY and RESPONSE (Describe results of any trial visits.)
	Describe patient's activities and his performance on work details, etc. How well does he take care of his personal needs?
	Describe ability to socialize with other patients and his relationship with staff members.
(7) POST HOSPITAL-IZATION	Describe medications and dosage prescribed as well as recommendations for any other modality of therapy.
(8) PATIENT'S ABILITY TO MANAGE HIS FUNDS (Must be Based on a Physician's Conclusion)	(a) In your opinion is the patient able to manage benefit payments in his (her) own interest? ☐ Yes ☐ No *A "yes" answer indicates he is able to use, or direct the use of his benefits for his own well being.* *The mere ability to sign his checks is not controlling.* (If " Yes" skip to 9)
	(b) If the answer is "No", please describe why the individual is, in your judgment, not able to manage benefit payments.
	(c) If you know who has assumed responsibility for the patient or who displays an active interest in his (her) welfare please give that person's name, address and relationship to the patient.
	Name / Address / Relationship to the patient

COMPLETE ITEM (9) ONLY IF PATIENT IS STILL HOSPITALIZED

(9) PROGNOSIS	Give prognosis and plans for release. If release is contemplated, discuss patient's ability to function in a competitive work environment.

SIGNATURE BLOCK	NAME AND ADDRESS OF INSTITUTION	SIGNATURE	
		TITLE	DATE