RESIDUAL FUNCTIONAL CAPACITY
MENTAL ASSESSMENT

Patient Name	**Social Security Number**

If additional room is needed to answer a question, please **use a separate sheet** of paper and reference which question you are addressing in your extended remarks.

PART I: TREATMENT PERIOD AND DIAGNOSIS

1. When did you first see the patient?

2. How often do you see the patient and when did you last see the patient?

3. What diagnoses are producing the limitations listed below?

   Axis I:

   Axis II:

   Axis III:

   Axis IV:

   Axis V:

Part II: ASSESSMENT OF RESIDUAL FUNCTIONAL CAPACITY

1. What was the patient's highest GAF in the past twelve months?
2. What is the patient's current GAF?
3. Assessing Residual Functional Capacity in the Workplace

In making the assessments below, **use the following definitions** and **assume ongoing forty-hour work weeks.**

None: No limitations in ability.
Mild: Limitations exist, but they are mild or don't persist
Moderate: Limitations are less that marked but exceed mild
Marked: Ability to function is seriously impaired
Extreme: Unable to function in this area

When making the assessment below, **consider whether there is evidence of alcohol or drug abuse in the patient.** If **so**, complete the assessment identifying any impairments that would exist due to mental illness alone, that is, that would exist if drugs or alcohol abuse were not present.

ABILITY	LEVEL OF IMPAIRMENT					
	None	Mild	Moderate	Marked	Extreme	Duration of limitation to date
Understanding and Memory						
Remember locations and procedures						
Understand and remember very short, simple instructions						
Understand and remember detailed instructions						
Sustained Concentration and Persistence						
Carry out short, simple instructions						
Carry out detailed instructions						
Maintain attention and concentration for extended periods						
Perform duties within a schedule and maintain regular attendance						
Maintain ordinary routine without supervision						
Work with or near others without being distracted by them						
Make simple work-related decisions						
Complete normal workday and work week without interruptions from psychologically related symptoms and maintain a consistent pace without rest periods of unreasonable length or number						

ABILITY	LEVEL OF IMPAIRMENT					
	None	Mild	Moderate	Marked	Extreme	Duration of limitation to date
Adaptation						
Respond appropriately to changes in work setting						
Be aware of normal hazards and take appropriate precautions						
Travel to unfamiliar locations or take public transportation						
Set realistic goals or make plans independently						
Tolerate normal levels of stress						
Social Interaction						
Interact appropriately with the public						
Ask simple questions or request assistance						
Accept instructions and respond appropriately to criticism from supervisors						
Get along with co-workers without distracting them or exhibiting behavioral extremes						
Maintain socially appropriate behavior and basic standards of neatness and cleanliness						

4. If you assessed "marked" or "extreme" limitation in areas of regular attendance and persistence throughout the workday, please explain. For example, how many days per month would the patient need to miss work either due to symptomology or to attend treatment appointments?

5. If you marked “marked” or “extreme” in areas of behavior control and or interpersonal interactions, please describe potentially disruptive behavior patient is likely to display.

6. Do you think the patient is malingering? What is the basis of your opinion?

7. In your opinion is the patient capable of handling disability benefits, if awarded, to *consistently* pay for shelter, shelter utilities, food, basic clothing and grooming supplies, and medical care before other purchases? If no, why not?

8. Are there any other factors that should be considered in evaluating the patient's abilities to work or perform activities of daily living. (For example, prone to decompensation?)

PART III: TREATMENT HISTORY

1. What medications have been tried? For each medication, include when medication was started (and stopped if applicable), effectiveness of treatment, any side effects, and the severity of side effects as they would impact on ability to function in workplace.

2. Were any medications stopped due to severity of side effects? If yes, please explain.

3. Has the patient undergone psychological or cognitive testing? What, when, and where?

4. What other treatments have been initiated? Describe the result/effectiveness of the treatments and dates applied?

5. Is the patient's care coordinated with care from other mental health providers? If yes, please explain and give providers names.

6. Is the patient's condition expected to improve? Deteriorate? Remain unchanged? Please explain the basis of your opinion. If change is expected, please indicate how soon and to what degree?

Signature	**Date**
Print Name	
Clinic, Facility, or Office	
Address	
Phone	**Email**