

## PSYCHIATRIC MEDICAL REPORT

**RETURN TO:** Tribal Government Retirement System c/o TGRS-MERS  
 1134 Municipal Way  
 Lansing, MI 48917  
 Phone: (877) 641-8477 • Fax: (517) 703-9706

**Instructions: Please type or print.** 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 by documentation in this report rather than on history or undocumented conclusions.

Please do not comment on determination of disability. Under the MERS Plan Document, “disability” is a legal term which is individually determined by consideration of all relevant factors in each case.

Name of Patient (Last, First, Middle)	Social Security No. <small>(last 4 digits only) -</small>	Date of Birth (MM/DD/YY)	
Street Address	Tribal Code	Daytime Phone No.	
Employed by: Tribe Name	City	State	Zip Code

**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.)

<b>HISTORY OF ILLNESS</b>	Approx. date illness began	Has illness caused weight loss? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has illness caused insomnia? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Describe any personality change, labile moods, etc.		
	Describe effect of illness on work.		
	Describe any further characteristics of illness.		

<b>MEDICATIONS</b>	List treatment/medications: Treating sources (i.e., physicians, hospitals, clinics), medications prescribed, compliance, any side effects, response to all treatment.
<b>PERSONAL HISTORY</b>	Describe how childhood, school, marriage, work, illness, alcohol, prison, etc. have impacted patient's current condition.
<p><b>DAILY FUNCTIONING:</b> 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, indicate 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. Depict any examples observed.</p>	
<b>SOCIAL FUNCTIONING</b>	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:
<b>INTERESTS</b>	Describe patient's interests. How has the illness affected his/her interests? Are interests realistic, grandiose, or manifestations of a delusion system?

<b>ACTIVITIES</b>	<p>Describe the patient's typical day - Shopping, house/car repairs, church, household chores, work, recreation, consider the 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?</p>
<b>OBSERVATIONS</b>	<p>Give details of patients visit. Was patient alone or accompanied? Describe height/weight, gait, posture, manners, clothing, hygiene, punctuality, difficulty remembering, or finding locations. Explain any assistance required in preparing for appointment (bathing, dressing, etc.).</p>
<b>ATTITUDE-BEHAVIOR</b>	<p>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?</p>

<b>MENTAL ACTIVITY</b>	Give examples of mental activity.	Describe speech. Place X in box of any that apply.  <input type="checkbox"/> Spontaneous <input type="checkbox"/> Pressured <input type="checkbox"/> Blocked <input type="checkbox"/> Slow <input type="checkbox"/> Illogical <input type="checkbox"/> Well Organized <input type="checkbox"/> Vague <input type="checkbox"/> Circumstantial <input type="checkbox"/> Other
		<input type="checkbox"/> If any of the above boxes are marked, you must explain in this area.

<b>EMOTIONAL REACTION</b>	Describe emotional reaction to visit.	Describe mental state. Place X in box of any that apply.  <input type="checkbox"/> Depressed <input type="checkbox"/> Fearful <input type="checkbox"/> Elated <input type="checkbox"/> Flat <input type="checkbox"/> Angry <input type="checkbox"/> Blunt <input type="checkbox"/> Suspicious <input type="checkbox"/> Friendly <input type="checkbox"/> Other
		<input type="checkbox"/> If any of the above boxes are marked, you must explain in this area.

<b>MENTAL TREND/THOUGHT CONTENT</b>		Place X in box of any traits that apply.  <input type="checkbox"/> Hallucinations <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Delusions <input type="checkbox"/> Unusual Powers <input type="checkbox"/> Persecutions <input type="checkbox"/> Worthlessness <input type="checkbox"/> Obsessions <input type="checkbox"/> Sleep disorders <input type="checkbox"/> Thoughts controlled by others <input type="checkbox"/> Weight gain/loss <input type="checkbox"/> Weakness
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**COMPLETE THIS SECTION WITH PATIENT'S ACTUAL ANSWERS**

<b>SENSORIUM AND MENTAL CAPACITY</b>		
<b>MENTAL CAPACITY</b>	Orientation: time, place, person	
	Memory	
	IMMEDIATE: How many numbers can be repeated? Forward	Backward
	RECENT: How many of three objects are recalled three minutes later?	
	PAST: Name the past three U.S. Presidents.  Tell your birthday.	
	Information Name five large cities.	
	Name three current famous people	
	Calculation	
Progressively subtract 7's from 100	<input type="checkbox"/> Correct <input type="checkbox"/> Incorrect	
Add and multiply single digits	<input type="checkbox"/> Correct <input type="checkbox"/> Incorrect	

<b>ABSTRACT THINKING</b>	Have the patient explain: "The grass is greener on the other side of the fence." "Don't cry over spilled milk "
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**Sensorium and Mental Capacity (continued)**

<b>SIMILARITIES AND DIFFERENCES</b>	<p>Have the patient explain: "How are a bush and a tree alike"?</p> <p>How are they different?</p>
<b>JUDGEMENT</b>	<p>Have the patient describe what they would do if they discover a fire in a theater.</p> <p>If they found a stamped, addressed envelope.</p>

Other information: Further describe psychosis, neurosis, personality disorders, mental deficiency, organic brain disease, epilepsy, suicidal ideas:

<b>DIAGNOSIS</b>	AXIS I	AXIS II
	AXIS III	AXIS IV
	AXIS V	★DSM-IV (or that of the current DSM) definitions, in numerical form, must be included with the diagnosis

Could this patient handle his/her insurance benefit funds? <span style="float: right;"><input type="checkbox"/> Yes    <input type="checkbox"/> No</span>			
<b>For attending physician:</b> Name		Date patient first seen	Date patient last seen
Street Address		City	State    Zip Code
Telephone Number	Specialty		
Signature of Physician			Date