

LIBERTY HOUSE FOUNDATION, INC.

54 BAY STREET

GLENS FALLS, NY 12801

PSYCHIATRIC DISABILITY MEDICAL REPORT FORM

(Please complete and return to Liberty House Foundation, Inc. at the above address or fax to (518) 798-1166.)

ALL INFORMATION IS KEPT CONFIDENTIAL IN ACCORDANCE WITH FEDERAL LAW

NAME OF INDIVIDUAL: _____ SSN: _____

ADDRESS: _____

PHONE #: _____ DOB: _____

AXIS I: _____

AXIS II: _____

AXIS III: _____

AXIS IV: _____

AXIS V: _____

AREAS OF FUNCTIONAL LIMITS (Check all that apply):

_____ **Communication** _____ **Interpersonal** _____ **Mobility** _____ **Self Care**

_____ **Self Direction** _____ **Work Skills** _____ **Work Tolerance**

Psychiatric History (onset, course, hospitalizations, treatments, etc.):

Current Findings (mental status, cognitive ability, affective derivatives, behavior, symptoms, organicity, stability of condition, etc.):

_____ **Date Last Examined**

_____ **Examined By**

Current medication and therapy (Type and frequency, progress to date and projected need):

Assessment of General Mental Health Status: _____ **Excellent** _____ **Good** _____ **Fair** _____ **Poor**

Discuss your opinion on the following factors to be considered in relation to training, education, and employment services:

A. Interpersonal Factors (source of support or stress in the home, environment and/or work situation that should be enhanced, modified or avoided):

B. Personal Awareness and Motivation (degree of understanding of capacities and limitations; realistic decision making skills; ability and willingness to participate in a structured work-related program):

C. Functional Limitations (response to pressure, supervision, working conditions, etc.):

Work ability estimate: _____ **Excellent** _____ **Good** _____ **Fair** _____ **Poor**

D. Other (pertinent factors which will assist in Liberty House's planning and working with the individual):

PLEASE SIGN BELOW:

(Signature Required - Physician (M.D.) or Licensed Psychologist (Ph.D.))

Date: _____

CONSENT: I hereby give my consent to release information from my records to Liberty House Foundation, Inc.

Signature: _____ **Date:** _____