

MEDICAL OPINION OF PHYSICIAN/THERAPIST RE: ABILITY TO DO WORK-RELATED ACTIVITIES (MENTAL)

NAME: _____ SSN: _____

To determine your patient's ability to do *work-related activities on a day-to-day basis in a regular work setting*, please give us your opinion -- **based on your examination** -- of how your patient's mental/emotional capabilities are affected *by the impairment(s), including side effects of any medications*. Consider the medical history, the chronicity of findings (or lack thereof), and the expected duration of any work-related limitations, but not the individual's age, sex or work experience. **DO NOT CONSIDER THE EFFECTS OF CURRENT ALCOHOL OR DRUG USE.**

For each activity shown below:

- a. *Describe your patient's ability to perform the activity according to the following terms:*

Unlimited or Very Good:	Ability to function in this area is more than satisfactory.
Good:	Ability to function in this area is limited but satisfactory.
Fair:	Ability to function in this area is seriously limited, but not precluded.
Poor or None:	No useful ability to function in this area.

- b. *Identify the particular medical or clinical findings (e.g., mental status examination, behavior, intelligence test results, symptoms) which support your opinion regarding any limitations.*

IT IS IMPORTANT THAT YOU RELATE PARTICULAR MEDICAL FINDINGS TO ANY REDUCTION IN CAPACITY; THE USEFULNESS OF YOUR OPINION DEPENDS ON THE EXTENT TO WHICH YOU DO THIS.

I.	MENTAL ABILITIES AND APTITUDE NEEDED TO DO UNSKILLED WORK	Unlimited or Very Good	Good	Fair	Poor or None
(1)	Remember work-like procedures				
(2)	Understand and remember very short and simple instructions				
(3)	Carry out very short and simple instructions				
(4)	Maintain attention for two hour segment				
(5)	Maintain regular attendance and be punctual within customary, usually strict tolerances				
(6)	Sustain an ordinary routine without special supervision				
(7)	Work in coordination with or proximity to others without being unduly distracted				
(8)	Make simple work-related decisions				
(9)	Complete a normal workday and workweek without interruptions from psychologically based symptoms				
(10)	Perform at a consistent pace without an unreasonable number and length of rest periods				
(11)	Ask simple questions or request assistance				
(12)	Accept instructions and respond appropriately to criticism from supervisors				
(13)	Get along with co-workers or peers without unduly distracting them or exhibiting behavioral extremes				
(14)	Respond appropriately to changes in a routine work setting				
(15)	Deal with normal work stress				
(16)	Be aware of normal hazards and take appropriate precautions				

- (17) Explain limitations falling into the fair and poor categories and identify the medical/clinical findings that support this assessment:

II.	MENTAL ABILITIES AND APTITUDES NEEDED TO DO SEMISKILLED AND SKILLED WORK	Unlimited or Very Good	Good	Fair	Poor or None
(1)	Understand and remember detailed instructions				
(2)	Carry out detailed instructions				
(3)	Set realistic goals or make plans independently of others				
(4)	Deal with stress of semiskilled and skilled work				

- (5) Explain limitations falling into the fair and poor categories and identify the medical/clinical findings that support this assessment:

III.	MENTAL ABILITIES AND APTITUDES NEEDED TO DO PARTICULAR TYPES OF JOBS	Unlimited or Very Good	Good	Fair	Poor or None
(1)	Interact appropriately with the general public				
(2)	Maintain socially appropriate behavior				
(3)	Adhere to basic standards of neatness and cleanliness				
(4)	Travel in unfamiliar place				
(5)	Use public transportation				

- (6) Explain limitations falling into the fair and poor categories and identify the medical/clinical findings that support this assessment:

IV. OTHER WORK-RELATED ACTIVITIES

State any other work-related activities which are affected by the impairment, and indicate how the activities are affected. What are the medical/clinical findings that support this?

V. On the average, how often do you anticipate that your patient's impairments or treatment would cause your patient to be absent from work?

Never

About once a month

About three times a month

Less than once a month

About twice a month

More than three times a month

VI. Based on your experience with your patient, what is the earliest date on which the above limitations apply? _____

VII. **CAPABILITY TO MANAGE BENEFITS**

Can your patient manage benefits in his or her own best interest?

Yes No

Date

Physician's/Therapist's Signature

§245.7

Printed/Typed Name: _____