**RAILROAD RETIREMENT BOARD MEDICAL ASSESSMENT OF MENTAL**

**RESIDUAL FUNCTIONAL CAPACITY**

**Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. 1. Nature frequency or length of contact**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

a. Summary of records or documents reviewed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ .

b. Assessment is: from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Specify applicable diagnoses, (check appropriate category(ies) upon which the medical disposition is based.

\_\_\_ 1. 12.02 Organic Mental Disorders, \_\_\_ 2. 12.03 Schizophrenic, Paranoid and Other Psychotic Disorder, 3. 12.04 Affective Disorders, \_\_\_ 4. 12.05 Mental Retardation \_\_\_ 5. 12.06 Anxiety-Related Disorders, \_\_\_ 6. 12.07 Somatoform Disorders \_\_\_ 7. 12.08 Personality Disorders \_\_\_ 8. 12.09 Substance Addiction Disorders \_\_\_ 9. 12.10 Autism and Other Pervasive Developmental Disorders 10. 12.11 Neurodevelopmental disorders, \_\_\_ 11. 12.13 Eating Disorders, \_\_\_ 12. 12.15 Trauma and stressor – PTSD and related disorders.

2. DSM-IV Multiaxial Evaluation: Axis I: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current GAF: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Axis II: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Axis III: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Highest GAF this past Year: \_\_\_\_\_\_\_\_\_\_\_

 Axis IV: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Axis V: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Treatment and response: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

4. Describe side effects of medication w/ implications for working: \_\_\_ excessive sleep, \_\_\_ drowsiness, \_\_\_ fatigue, \_\_\_ decreased ability to concentrate: (other) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

5. Describe *clinical findings* including results of IQ or mental status examination that demonstrate the severity of the claimant’s mental impairment and symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

6. Prognosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

7. Identify patient’s signs and symptoms:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

8. Patient \_\_\_\_ **does** \_\_\_\_ **does not** : have a low IQ or reduced intellectual functioning.

a. The claimant’s IQ can reasonably be estimated to be: \_\_\_\_ 69 and below \_\_\_\_ 70-84, \_\_\_ 85 and above. Please explain (w/re to specific test results if possible): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

9. Does the psychiatric condition exacerbate the claimant’s experience of pain or any other physical symptom/s? \_\_\_\_\_\_ Yes No If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

10. The claimant’s mental condition \_\_\_\_ **has** \_\_\_\_ **has not** lasted or can it be expected to last at least 12 months.

11. The claimant’s impairments \_\_\_\_ **are** \_\_\_\_ **are not** reasonably consistent with the symptoms and functional limitations described in this Evaluation and clinical presentation.

13. Is use of illicit drugs or alcohol a major contributing factor to patient’s mental impairment? \_\_\_\_\_ yes \_\_\_\_\_ no

B. **Criteria of the Listings**

The following is an indication as to what degree the following functional limitations (which are found in paragraph B of listings 12.02-12.04, 12.06-12.08 and 12.10 and paragraph D of 12.05) exist as a result of the individual’s mental disorder(s). The following definitions apply: “**Mild**” is defined as affecting the claimant between 1% to 5% of an 8 hour work-day, “**Moderate**” between 6% and 33%, “**Marked**”, between 34% and 66%, “**Extreme**”, 67% or more of an 8 hour day.

 **FUNCTIONAL LIMITATION DEGREE OF LIMITATION**

1. Restriction of ADL \_\_ None \_\_ Mild \_\_ Moderate \_\_ Marked\* \_\_ Extreme\* \_\_ Insufficient Evidence

 (Activities of Daily Life)

2. Difficulties in Maintaining

 Social Functioning: \_\_ None \_\_ Mild \_\_ Moderate \_\_ Marked\* \_\_ Extreme\* \_\_ Insufficient Evidence

3. Difficulties in Maintaining Concentration, Persistence or pace required to perform simple, routine repetitive

 Tasks: \_\_ None \_\_ Mild \_\_ Moderate \_\_ Marked\* \_\_ Extreme\* \_\_ Insufficient Evidence

4. Repeated Episodes of Decompensation, each of 1 week or more resulting in patient’s inability to engage in

 Full-time regular employment: \_\_ None \_\_ Mild \_\_ Moderate \_\_ Marked\* \_\_ Extreme\* \_\_ Insufficient Evidence

**C. Criteria of the Listings**

1. **Please complete this section & check the appropriate box as apply to the patient:**

Medically documented history of a chronic **organic mental** (12.02), **schizophrenic**, etc. (12.03), or **affective** **disorder** (12.04) of at least 2 years duration that has caused more than a minimal limitation of ability to do any basic work activity, with symptoms or signs currently attenuated by medication or psychosocial support, **and one of the following:**

\_\_\_ Repeated episodes of decompensation, each of extended duration \_\_\_ A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate

\_\_\_ Current history of 1 or more years inability to function outside a highly supportive living arrangement with an indication of continued need for such an arrangement

\_\_\_ **Complete** inability to function independently outside the area of one’s home

D. **Concentration and Attendance**

Regarding the following question, “**Rarely**” means 1%-5%, “**Occasionally**” means 6%-33%, “**Frequently**” means 34%-66%, “**Constantly**” means over 66% of an 8-hour working day. With those descriptions in mind, please answer the following question.

1. How often during a potential 8 hour work day would the patient be reasonably expected to experience psychiatric symptoms or the effects from prescribed medication that severe enough to interfere with attention and concentration needed to perform even simple routine repetitive tasks?

 \_\_\_\_ **Never** \_\_\_\_ **Rarely** \_\_\_\_ **Occasionally** \_\_\_\_ **Frequently** \_\_\_\_ **Constantly**

1. On the average, it is reasonably anticipated that anticipate that the claimant’s psychiatric impairments, medications or treatment would cause the claimant to be absent from work as follows:

 \_\_\_ **Never** \_\_\_ **1 day/month month** \_\_\_ **About 2 days/month** \_\_\_ **About 3 days/ month**

 \_\_\_ **About 4 days per month** \_\_\_ **More than 4 days per month**

1. Additional reasons not covered above why the claimant would have difficulty working at a regular job on a sustained basis not covered above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. T**he earliest date prior to the date of completion that the description of symptoms and limitations in this**

**form applies is :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician’s Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** **Completed**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician must be an M.D., D.O., PhD, or PsyD**

**Printed/Typed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_ **Or Please Attach Physician’s Business**

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Card hereunder.**

Please Return from to:

Mike Murburg, P.A.
15501 N. Florida Ave.

Tampa, FL 33613

Tel (813) 264-5363 Fax (813) 961-6011