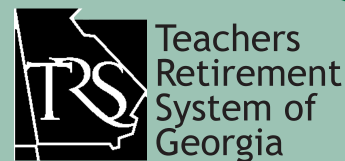
Psychiatrist's, Psychologist's or Counselor's Report



This form pertains to those members applying for Disability Retirement. TRS guarantees the confidentiality of the information provided on this form.

As a member of the Teachers Retirement System of Georgia (TRS), it is your responsibility to obtain the necessary medical information from all treating sources needed to determine the status of your disability retirement request. Any charges for this information will be at your expense. In some cases, TRS may require an evaluation by an independent treatment provider of our choice. If this is necessary, you will be notified and TRS will assume the responsibility for that cost only.

You need to send one of these reports to EACH psychiatrist, psychologist, or counselor from whom you have received treatment/diagnosis for your medical condition(s) in the last 12 months. You must attach a copy of your current job description to each report. Job descriptions are available from your personnel department.

If this form is completed by a licensed social worker or psychologist, the medical doctor who referred you must sign it as well.

▼ To Be Completed by Member -- *please print clearly*

| | | | - | | | - | | | | |

Social Security Number

____
Date of Birth

_______________________ Last Name
_______________________ First Name
__________ Middle Initial

____
Street Address or P.O. Box

(_________)_______________
Telephone Number (daytime)

_______________________ City
__________ State
__________ Zip Code

____
Name of Treating Source

(_________)_______________
Phone Number of Treating Source

____
Address of Treating Source

_______________________ City
__________ State
__________ Zip Code

Authorization for Release of Medical Information

This is my written authorization to release to the Teachers Retirement System of Georgia any and all medical records and information for the purpose of processing my disability retirement application. This includes any psychiatric/psychological records.

____
Signature

____
Date

After completing this section, please forward this report to your psychiatrist, psychologist or counselor. If you have been treated/diagnosed by more than one in the last 12 months, you must send a copy of this report to each one. *Do not forget to attach a copy of your job description to each report.*

▼ To Be Completed by Treating Source -- *please print clearly*

Please complete all 4 pages of this form.

This person has applied for disability retirement with the Teachers Retirement System of Georgia and you have been named as a treatment provider. Your information is vital in determining disability status for the job currently held. A job description is attached for your review. TRS needs a current evaluation. Please state specifically whether or not you determine that this person is disabled for the current job held. The person has signed above authorizing the release of all medical information. If a licensed social worker or psychologist is completing this form, it must also be signed by the referring medical doctor.

Please bill the person named above for any charges relating to this request. Thank you for your cooperation.

Ability to Perform Job

For the currently held position, and according to the job description attached, I find that this person is:

Able to perform the job as described. ❑**Yes** ❑**No**

Two Northside 75 ● Suite 100 ● Atlanta, GA 30318 ● (404) 352-6500 ● (800) 352-0650 ● fax (404) 352-4885 ● www.trsga.com

Psychiatrist's, Psychologist's or Counselor's Report cont.

▼ To Be Completed by Treating Source -- *please print clearly*

Patient's Last Name ______ First Name ______ Social Security Number ______

Job Duties

Please state the job duties that the person cannot perform.

Present Illness

Please describe:

1. The patient's mental condition
2. Age at onset
3. Diagnosis
4. Symptoms supporting diagnosis (include any history of substance abuse or violent behavior)
5. Treatment (past, present, medication, response, compliance and side effects--include photocopies of progress notes and hospital discharge summaries if available)

1. ______
2. ______
3. ______
4. ______
5. ______

Past History

Please list the significant physical/mental factors in patient's background (serious historical illness or disability of patient or family members)

Daily Activities

Please include examples and information on how independently the patient acts, however long he/she is able to sustain activities, and the quality and appropriateness of the activities.

1. Describe a typical day (yard work, house work, cooking, TV, visiting, etc.)

2. Interests (hobbies, sports, social and church activities, etc.)

3. Ability to relate to others (frequency of trips outside the home, freqency and quality of interactions with friends, family, neighbors, crowds, etc.)

4. Personal habits (appearance, grooming habits, personal hygiene, clothing, etc.)

5. Current ability to function in a work setting (ability to concentrate, pay attention, sustain pace, understand and remember directions, and adapt to changes)

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Patient's Last Name ______________________ First Name ______________________ Social Security Number ______________________

Current Mental Status

Please describe the following by using illustrative incidents when possible.

1. Behavior and interaction with therapists (appropriate, hostile, suspicious, aggressive, evasive, passive, dramatic, etc.)

2. Psychomotor behavior (agitation, retardation, tics, tension, tremors, etc.)

3. Speech (slow, loud, pressured, understandable, impaired in any way)

4. Mood/Affect/Facial Expression (quantity, appropriateness, type, range of feelings expressed, lability, eye contact, etc.)

5. Sensorium/Perceptual abnormalities (disoriented, delusional, hallucinations, etc.)

6. Flow of thought (loose associations, coherent, rambling, perseverative, etc.)

7. Content of thought (illogical, apprehensive, obsessive, suicidal, etc.)

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Psychiatrist's, Psychologist's or Counselor's Report cont.

▼ To Be Completed by Treating Source -- *please print clearly*

Patient's Last Name	First Name	Social Security Number

Current Mental Status cont.

Please describe the following by using illustrative incidents when possible.

8. Memory (remote, recent, immediate)

9. Attention and consciousness (impaired in any way by illness, injury, drugs, etc.)

10. Estimated intelligence and ability to concentrate/focus

11. Reliability of patient's report

12. Physical condition (include unrealistic beliefs about personal illness or complaints of chronic pain)

13. Specific symptoms (low energy level, insomnia, guilt, poor appetite and weight loss, anhedonia, autonomic hyperactivity, vigilance and scanning, phobias, intrusive and traumatic recollections, substance abuse, etc.)

Other Information

Please provide any other information that you think will assist in the determination of this patient's claim for disability.

Physician's Authorization

By signing, you certify that the information provided above is accurate.

Confidentiality will be maintained.

Signature of Physician

Signature of MH Professional

Physician's Name Printed — Date

MH Professional's Name Printed — Date

After completing this report, please forward it, along with any attachments, directly to TRS. We appreciate your assistance.

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