Verification of Mental Health Disorder/Brain Injury (Supplementary Information Request)

NOTE: Forms completed or altered by anyone other than the Certifying Medical Professional whose signature appears on this form will not be processed.

Patient Information	
Legal Name:	Date of Birth (MM/DD/YYYY):

Please check one: I certify that I am a ☐ **Registered Psychologist**, ☐ **Psychiatrist**, or a ☐ **Physician** with expertise in diagnosing and/or treating the condition(s) indicated below.

1. Indicate your **DSM-IV** or **DSM-5** or **ICD diagnosis** for the Patient:

DSM-IV/DSM-5/ICD Diagnosis	DSM/ICD Diagnostic Code	Date of Onset	Expected to Persist ☑
			☐ Less than 2 years ☐ 2 + years ☐ Not expected to improve
			☐ Less than 2 years ☐ 2 + years ☐ Not expected to improve
			☐ Less than 2 years ☐ 2 + years ☐ Not expected to improve

2. In addition to the DSM criteria, I certify that I used the following **diagnostic measures** to arrive at the diagnosis (please check all relevant items below):

☑	Diagnostic Measures Used (check all that apply)		
☐	Structured/unstructured interviews with patient	☐	Developmental history
☐	Interviews with other persons	☐	Educational history
☐	Behavioural observations	☐	Medical history
☐	Neuropsychological testing (**enclose report** if completed within last 5 years)		
☐	Standardized or non-standardized rating scales (please specify): →		
☐	Other (please specify): →		
☐	**I did not diagnose the Patient**. S/he was diagnosed by Dr. _____ on (date) _____. (**Please enclose report from original assessor/diagnostician.**)		

3. List the major symptoms of the disorder that **currently affect the Patient** (be sure to include any significantly impairing side effects from medication that affect the Patient; attach an additional sheet if required):

Symptom	Persists with Treatment ☑	Frequency			
		Daily	Weekly	Monthly	Other (Specify)
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	

4. Indicate on each scale below the number that best represents the Patient's **current level of functioning**, *even with treatment*, for the activities of daily living listed below.

School/Work/Life Activity	No Limitation ⟶ Totally Impaired	Unknown/Not Assessed ☑
Staying on task	1----------2----------3----------4----------5	☐
Following simple instructions	1----------2----------3----------4----------5	☐
Following complex instructions	1----------2----------3----------4----------5	☐
Reading a scholarly article	1----------2----------3----------4----------5	☐
Reading a newspaper article	1----------2----------3----------4----------5	☐
Taking notes in class	1----------2----------3----------4----------5	☐
Living alone	1----------2----------3----------4----------5	☐
Sleeping	1----------2----------3----------4----------5	☐
Eating	1----------2----------3----------4----------5	☐
Interacting socially	1----------2----------3----------4----------5	☐
Managing self care	1----------2----------3----------4----------5	☐
Managing internal distractions	1----------2----------3----------4----------5	☐
Managing external distractions	1----------2----------3----------4----------5	☐
Completing tasks on time	1----------2----------3----------4----------5	☐
Attending classes regularly	1----------2----------3----------4----------5	☐
Making/keeping appointments	1----------2----------3----------4----------5	☐
Managing stress	1----------2----------3----------4----------5	☐
Organizing	1----------2----------3----------4----------5	☐
Other: _____	1----------2----------3----------4----------5	

5. Indicate the following:

   a. Date the Patient was first seen by you: _____

   b. How frequently you have treated the Patient **in the past 2 years**[1] (choose only one):

   ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Quarterly ☐ Annually ☐ Other: _____

6. Is there **anything else** you think we should know about the Patient's disorder (including suggestions for support)?

Certifying Medical Professional

*I certify that the information provided on this form is **accurate** to my knowledge and that the person identified in this assessment as "the Patient" **experiences the impairments** I have indicated.*

Name of Certifying Medical Assessor:		Registration/Certificate#:
Occupation of Medical Assessor:		Telephone Number:
Mailing Address:		Fax Number:
City/Town:	Province:	Postal Code:
Signature (in ink):		Date:
		STAMP

1 **Note to Applicant:** A short case history with your doctor may require additional medical documentation from your current and/or previous doctor.