The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of Adult Career and Continuing Education Services
Vocational Rehabilitation (ACCES-VR)

Confidential Medical Report Psychiatric Disability

VR-119 (1/11)

Psychiatrist or Clinical Psychologist Name and Address:

Please return this completed form to:

ACCES-VR Counselor Requesting Information

ACCES-VR Office Address

City, State, and Zip

ACCES- VR Telephone Number

Consumer Name (First, Middle *Initial, Last)*

Date of Birth *(Month, Day, Year)*

1. Salient Psychiatric History (onset, course, hospitalizations, treatments, etc.)-

2. Psychiatric Diagnosis (APA nomenclature - DSM 111):

Category 1 _____ Axis _____

2 _____ _____

3 _____ _____

Other (non-psychiatric) _____

3. Additional Studies (psychological tests, CNS studies, perception, laboratory, etc.)-

Performed — Results:

Recommended — Reasons:

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

5. Current Medication and Therapy (type and frequency, progress to date, projected need):

Mental health estimate ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of primary therapist _____

Title _____ Telephone Number _____

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

A. Interpersonal Factors (sources 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 ACCES-VR's planning and working with the individual):

_____ Date Last Examined

_____ Examined by

_____ Date of Report

_____ Completed by

Report must be signed or co-signed by a qualified psychiatrist or licensed clinical psychologist

_____ Signature

_____ Date