# PHYSICIAN CERTIFICATION OF ADULT WITH A SERIOUS MENTAL ILLNESS

**CLIENT NAME** First: _____Last:_____**SOC. SEC. NO.** _____

**SEX**: M F **RACE**: (Circle all that apply): WH AS BL AI/AN NH/OPI **ETHNIC HISPANIC** ___

**PROVIDER**_____ **CLIENT ID NO.**_____ **DATE OF BIRTH** ____/____/_____

**AXIS I & II CODES** (Principal Dx 1st) _____ **GAF** _____

Adults with a serious mental illness are persons age 18 and over:

- who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM IV, **OTHER THAN** "V" codes, substance use disorders or developmental disorders (including mental retardation and pervasive developmental disorders) which are excluded unless they co-occur with another diagnosable serious mental illness.
- **AND** this disorder has resulted in functional impairment which meets one of the criteria below for substantially interfering with or limiting one or more major life areas (Persons who would have met functional impairment criteria during the past year without the benefit of treatment or other support services are considered to meet the functional impairment criterion for serious mental illness). **Check which apply, if the first or second criterion set below is checked it is not necessary to check the third criterion set:**

___ At any point in life have met the diagnostic criteria for Schizophrenia, Schizoaffective Disorder or Bipolar I Disorder, **or**

___ During the past year have met diagnostic criteria for Major Depression, Panic Disorder or Obsessive-Compulsive Disorder, or at any point in life have met diagnostic criteria for Bipolar II Disorder; **AND**, during the past year meet at least one of the following severity criteria: inpatient psychiatric hospitalization, psychotic symptoms, use of antipsychotic medications, or a GAF of 50 or less, **or**

___ During the past year met at least one of the criteria listed below (Check all that apply):

- ____ Either planned or attempted suicide during the past 12 months
- ____ Lacked any legitimate productive role
- ____ Had a serious role impairment in their main productive roles, for example consistently missing at at least one full day of work per month as direct result of their mental health
- ____ Had serious interpersonal impairment as a result of being totally socially isolated, lacking intimacy in social relationships, showing inability to confide in others, and lacking social support.
- ____ Had difficulties that substantially interfered with or limited role functioning in basic daily living skills (e.g. eating, bathing, dressing)
- ____ Had difficulties that substantially interfered with or limited role functioning in instrumental living skills (e.g. maintaining a household, managing money, getting around the community, taking prescribed medication)
- ____ Had difficulties that substantially interfered with or limited functioning in social, family or vocational/educational contexts. DESCRIBE_____

_____

**I, the undersigned, do hereby certify that I have performed a medical review of the evaluation of this client and that he/she meets the above DMHS criteria for adults with a serious mental illness.**

**____Evaluation based on my direct examination of client within last 45 days (Valid up to one calendar year)**

**____Evaluation not based on my direct examination of client within last 45 days (Valid up to 45 days)**

**____Evaluation based on my participation in ongoing treatment planning/review process (Valid for period of validity of current physician approved treatment plan)**

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**Physician Signature** **Date of Medical Review** **Revised 01/24/05**