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Attending Physician Statement for Behavioral Health
To be completed by physician

Patient's Name: **Date of Birth:**

Claim Number: **Medical Due Date:**

The patient's current disability plan requires that medical information indicate an inability to perform the essential duties of his/her own job. Patient's occupation: _____

Have you recommended to your patient to stay home from work? ☐ Yes ☐ No If yes, effective what date?_____

Please provide your rationale for recommending the patient stay home from work _____

Can your patient return to work with accommodations? ☐ Yes ☐ No If yes, effective what date? _____

Please describe accommodations:_____

_____

Your patient will be released to work full duty on: _____

DIAGNOSIS

Primary: ICD Code: _____ Description: _____

Secondary: ICD Code: _____ Description: _____

COGNITIVE FUNCTIONING EVALUATION

Applied focus and concentration in session for periods of:

☐ 30 to 50 minutes ☐ 15 to 30 minutes ☐ 5 to 10 minutes ☐ less than 5 minutes

Expressed his/her current circumstances and responded to direct questions appropriately: ☐ Yes ☐ No

If no, was redirection needed? ☐ Yes ☐ No Please describe:_____

Reasoning and/or judgment: ☐ Within normal limits ☐ Impaired If impaired, please describe:_____

Delusional ideations evident: ☐ Yes ☐ No If yes, please describe:_____

Hallucinations reported: ☐ Yes ☐ No If yes, please describe:_____

Memory functions: Four unrelated words after five minutes: _____ Other testing results: _____

Able to perform five operations of Serial 7's or 3's: ☐ Yes ☐ No Exam findings: _____

Able to follow direction and verbalize directions given during exam? ☐ Yes ☐ No If no, please describe:_____

Able to read a narrative paragraph from a magazine or newspaper and report the main concept/idea of the passage: ☐ Yes ☐ No

EMOTIONAL FUNCTION AND BEHAVIORAL OBSERVATIONS

Date of last exam: _____Behaviors and emotional state observed during exam: _____

_____

Able to spontaneously compose her/himself: ☐ Yes ☐ No If no, please explain:_____

Psychomotor activity and ability to apply effort: ☐ Unremarkable ☐ Impaired If impaired, describe: _____

Presented with appropriate dress and hygiene in session: ☐ Yes ☐ No If no, please describe:_____

Impulse control: ☐Physical abusive behavior ☐ Verbal abusive behavior ☐Substance abuse/addiction
☐Alcohol abuse/addiction ☐Manic Behavior

Speech: ☐ Slurred ☐ Pressured ☐ Stammering ☐ Loud ☐ Soft ☐ Over productive ☐ Under productive
☐ Other (please describe)_____

Risk to self/others:

SUICIDAL IDEATIONS ☐ Yes ☐ No Plan reported: ☐ Yes ☐ No If yes, please explain:_____

HOMICIDAL IDEATIONS ☐ Yes ☐ No Plan reported: ☐ Yes ☐ No If yes, please explain:_____

Able to report reasons for not harming self/others: ☐ Yes ☐ No If no, please explain:_____

Contracted for safety: ☐ Yes ☐ No If no, please explain:_____

PATIENT SELF REPORT OF ACTIVITIES OF DAILY LIVING

Is the patient currently performing any of the following? ☐ Volunteer work ☐ Works at a lesser demanding job ☐ Attending school ☐ No work activities in any capacity ☐ Self-employment

Has the patient conceptualized the following areas as barriers in returning to work:

☐ Increase in work demands ☐ Conflicts with supervisor ☐ Anticipation of relapse

☐ Recent unfavorable work evaluation ☐ Dissatisfaction with the job ☐ Other (please specify)_____

Has the patient expressed or are you aware that she/he is experiencing any psychosocial stressors? ☐ Yes ☐ No If yes, please describe:_____

Significant weight changes: ☐ Yes ☐ No Current weight:_____ Previous weight:_____Date of previous weight:_____

Significant appetite changes: ☐ Yes ☐ No If yes, please describe diet:_____

Significant sleep disturbance: ☐ wakes more than twice per night ☐ sleeps less 4 hours or less ☐ sleeps 12 hours or more

Are any of the above weight, appetite, or sleep disturbances related to medication side effects? ☐ Yes ☐ No If yes, please describe:_____

Panic attacks: ☐ Yes ☐ No If yes, please specify below:

- Frequency of panic attacks:_____
- Duration of panic attacks:_____
- Symptoms experienced during panic attacks: _____

Socialization problems: ☐ Yes ☐ No If yes, please describe:_____

Is patient able to: Clean/maintain residence: ☐ Yes ☐ No Perform routine shopping: ☐ Yes ☐ No

Pay bills: ☐ Yes ☐ No Operate motor vehicle: ☐ Yes ☐ No

If no to any of these above, please explain:_____

TREATMENT

Date initiated care: _____

Inpatient care: Dates of hospitalization: _____ Partial hospitalization programs: Dates of care: _____

Intensive outpatient (IOP): Start date: _____ End date: _____

Days per weeks: _____ Hours per day: _____

Outpatient psychotherapy: Frequency: _____ Date of next visit: _____

Medication management: Frequency: _____ Date of next visit: _____

Current medications/changes in medication-list all medications and identify dates of new medications or dose adjustments: (attach list if necessary)

Medication	Dose	Frequency	Duration	New Medication	Date prescribed	Adjusted Medication	Date Adjusted
				Yes ☐ No ☐		Yes ☐ No ☐	
				Yes ☐ No ☐		Yes ☐ No ☐	
				Yes ☐ No ☐		Yes ☐ No ☐	

Medication side effects: ☐ Yes ☐ No If yes, please describe:_____

Attach if relevant all office notes, history & physical, results of x-rays, laboratory tests, MRI Reports, etc.

"The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

Telephone Number: _____ Physician/Provider Printed Name: _____

Fax Number: _____ Physician/Provider Specialty: _____

Date Completed: _____ Physician/Provider Signature: _____