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Attending Provider Statement: Initial Mental Health

Health Care Provider, your full completion of this form is necessary so that the employee's application for benefits may be received and processed*. Note that sections 3, 4, and 5 allow you to indicate if impairment is present or absent. If impairment is absent, you may skip the detailed assessment questions associated with that specific section of the form.*

<table>
<tr><td>Patient Information</td><td colspan="2">First Name:</td><td colspan="2">Last Name:</td><td colspan="2">Date of Birth:</td><td>Gender:</td></tr>
<tr><td rowspan="11">Treatment & Statement of Incapacity</td><td colspan="2">First Office Visit:
_____/_____/_____</td><td colspan="2">Last Office Visit:
_____/_____/_____</td><td colspan="3">Next Office Visit:
_____/_____/_____</td></tr>
<tr><td colspan="4">Primary Disabling Diagnosis:</td><td colspan="3">DSM/ICD Code:</td></tr>
<tr><td colspan="4">Co-Morbid Conditions Impacting Work Capacity:</td><td colspan="3">DSM/ICD Code:</td></tr>
<tr><td colspan="4"></td><td colspan="3">DSM/ICD Code:</td></tr>
<tr><td colspan="7">In your clinical opinion, has your patient recently suffered from a disabling behavioral health disorder that precludes work?
☐ No. If no, please provide a work release per section #7 below (Return to Work Status & Plan).
☐ Yes starting on the following date ____/____/____ through ____/____/____</td></tr>
<tr><td colspan="7">If yes, please provide a detailed rationale supporting your recommendation for disability benefits in the space below:</td></tr>
<tr><td colspan="7">Intensity of Care (Check all that apply):
☐ Inpatient Care: Admitted on: ____/____/____ Actual or Expected Discharge Date: ____/____/____
Name and Address:
_____
☐ Partial Hospitalization: Admitted on: ____/____/____ Actual or Expected Discharge Date: ____/____/____
Days per week: _____ Hours per day: _____
☐ Intensive Outpatient (IOP): Admitted on: ____/____/____ Actual or Expected Discharge Date: ____/____/____
Days per week: _____ Hours per day: _____
☐ Outpatient Psychotherapy: Frequency: _____ Date of next scheduled visit: ____/____/____
☐ Medication Management: Frequency: _____ Date of next scheduled visit: ____/____/____</td></tr>
<tr><td colspan="2">Name:</td><td colspan="2">Name:</td><td colspan="3">Name:</td></tr>
<tr><td colspan="2">Dosage:</td><td colspan="2">Dosage:</td><td colspan="3">Dosage:</td></tr>
<tr><td colspan="2">Frequency:</td><td colspan="2">Frequency:</td><td colspan="3">Frequency:</td></tr>
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<table>
<tr><td></td><td>Start date: ____/____/____</td><td>Start date: ____/____/____</td><td>Start date: ____/____/____</td></tr>
<tr><td></td><td colspan="3">Medication side effects impacting work capacity:
☐ None
☐ Present, as described below:</td></tr>
<tr><td></td><td colspan="3">List other health care provider(s) currently treating and/or scheduled to treat the patient for their behavioral health disorder below:</td></tr>
<tr><td rowspan="8">Patient's Self Report of Symptom Impacting Functioning</td><td colspan="3">Clinically significant weight changes
☐ Not Applicable
☐ Yes, note weight amount and specify time period_____</td></tr>
<tr><td colspan="3">Insomnia:
☐ Not Applicable
☐ Yes, indicate type and average hours of sleep per night
_____</td></tr>
<tr><td>Maintains residence:
☐ Yes ☐ No</td><td>Performs routine shopping:
☐ Yes ☐ No</td><td>Pays bills:
☐ Yes ☐ No</td><td>Drives:
☐ Yes ☐ No</td></tr>
<tr><td colspan="3">If no to any of the 4 items above, describe impairment in this space below:</td></tr>
<tr><td colspan="3">Socialization problems:
☐ No ☐ Yes, describe
_____</td></tr>
<tr><td colspan="3">Currently performs:
☐ Volunteer work ☐ Work in a lesser demanding job ☐ In role as primary care giver for a child under age 18</td></tr>
<tr><td colspan="3">Assists with the care of a handicapped family members or significant other
☐ No ☐ Yes, describe
_____</td></tr>
<tr><td colspan="3">Describe any other relevant Activities of Daily Living (ADL) performed or impaired that is relevant to current work leave:</td></tr>
<tr><td>Affect & Mood Assessment</td><td colspan="3">Upon examination, it is my opinion that my patient's ability to modulate his/her affect at work is:
☐ Within Normal Limits (WNL) → Proceed to Section 4 (Behavioral Functioning-Clinician Observed).
☐ Functionally Impaired → Complete the following subsections before advancing to Section 4</td></tr>
</table>

	Please Provide Detailed Behavioral Observations if Impairment is determined based upon your treatment sessions. **Affect & Mood displayed during encounters (Describe type, intensity, behavioral correlates, and appropriateness):** ☐ WNL ☐ Impaired as evidenced by the following: **Ability to self-compose and display appropriate affect within the context of your sessions:** ☐ WNL ☐ Impaired as evidenced by the following: **Anxiety features observed in session impacting work capacity:** ☐ Not Applicable ☐ Present, as evidenced by the following: **Primary Symptoms experienced:** 1. _____ 2. _____ 3. _____ 4. _____ **Panic Attacks impacting ADLs and/or Work functions:** ☐ Not Applicable ☐ Present, as evidenced by the following: **Primary Symptoms experienced:** 1. _____ 2. _____ 3. _____ 4. _____ **Frequency of panic attacks (e.g., 1x per day/week/month):** _____ **Average time duration of each panic attack**: _____ **Known psychological Triggers:** ☐ No ☐ Yes, describe: _____
Behavioral Functioning Clinician Observed	***Upon examination, it is my opinion that my patient's ability to provide appropriate effort at work is:*** ☐ Within Normal Limits → Proceed to Section 5. ☐ Impaired → Complete the following Behavioral functioning subsections before advancing to Section 5.
	Please Provide Detailed Behavioral Observations if Impairment is determined based upon your treatment sessions. **Psychomotor activity and ability to apply effort:** ☐ WNL ☐ Impaired, as evidenced by: **Presented with appropriate dress and hygiene in session?** ☐ WNL ☐ Impaired, as evidenced by: **Substance abuse, Compulsive behavior, Manic or Hypomanic features:** ☐ N/A ☐ Present, describe: **Suicidal ideations present that impact work capacity:** ☐ N/A ☐ Yes, explain: **Aggressiveness, Irritability, and/or Homicidal ideations that impact work:** ☐ N/A ☐ Yes, explain:
	Upon examination, it is my opinion that my patient's ability to perform cognitively at work is:

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Cognitive Functioning Assessment	☐ Within Normal Limits → Proceed to Section 6. ☐ Impaired → Complete the following cognitive functioning subsections before advancing to Section 6.
	If impaired, do you believe the patient is competent to endorse checks and direct the use of proceeds thereof? ☐ Yes ☐ No If no, please explain:
	Attention and Concentration: ☐ **Not assessed** *Serial 7's from 100 Answers: ____, ____, ____, ____, ____, ____ OR Serial 3's from 20: ____, ____, ____, ____, ____, ____* ***(93) (86) (79) (72) (65) (58) (17) (14) (11) (8) (5) (2)***
	Comprehension: ☐ **Not assessed** Impairment: ☐ Not noted ☐ Evidenced by: _____ Able to read a paragraph of text and report the main concept/idea of the passage: ☐ Not assessed ☐ Yes ☐ No, as evidenced by:
	Memory Functions: ☐ **Not assessed** 7 Digit Recall Forward (9, 7, 2, 4, 3, 0, 5): response_____ 5 Digit Recall Backwards (8, 0, 5, 2, 7): response_____ Immediate and delayed recall of 5 unrelated words presented orally: Immediate_____ 5 minutes_____ 10 minutes_____ Other Performance-based exam findings of cognitive capacity, e.g., WMS, WAIS Scaled Scores, etc., _____
	Thought Processes: Delusional ideations: ☐ No ☐ Yes, describe: _____ Speech: ☐ WNL ☐ Impaired, describe: _____ Thought Organization & Content: ☐ WNL ☐ Impaired, describe: _____
	Executive Functioning: Reasoning, Judgment, and Self-regulation: ☐ WNL ☐ Impaired, describe: _____
	Perceptual Disturbances: Hallucinations or Dissociative episodes: ☐ Not Applicable ☐ Self-reported ☐ Clinician observed. Describe if symptoms are present:
Additional Factors Impacting Return to Work Plans	**My Patient has reported the following which may influence my patient's return to work plans:** ☐ **Not Applicable** ☐ Recent increase in work demands ☐ Conflict with supervisor ☐ Recent unfavorable work evaluation ☐ General dissatisfaction with job ☐Other, e.g., care of a family member, describe:

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Return to Work Status & Plan	1.* ☐ Released to **Full time, Full Duty** (no restrictions or limitations) release date _____/_____/_____ 2.* ☐ Released to **Modified/Transitional Duty** on _____/_____/____ and **full duty** as of _____/_____/_____ 3.* ☐ Released back to work on _____/_____/_____ with **permanent restrictions and/or accommodations**: ***Note: If restrictions/accommodations are prescribed, please specify parameters with supporting clinical rationale below:*** ***If patient has not yet sufficiently recovered to perform work in any capacity, estimate the following:*** 1. ☐ Return work date as of: _____/_____/_____ 2. ☐ Significant clinical improvement by: _____/_____/_____ 3. ☐ The patient will reach maximum medical improvement by: _____/_____/_____ 4. ☐ The patient will need permanent work restriction and/or accommodations as follows:		
Teleconference	**If my patient's work capacity appears unclear, I am willing to participate in a brief (5 to 10 minute) teleconference with a clinician.** ☐ Yes, on the following days and time slots: Day(s) of the week: _____ Hours of the Day: _____ ☐ No, However, I would be willing to respond in writing to specific questions via email or fax _____		
Credentials	Provider's full name (please print):	Specialty:	Degree:
	Address (No., Street, City, State, Zip Code):	Phone:	Fax:
Version: 4-8-2022	**Signature:**	**Date Completed:** _____/_____/_____	

Please fax to Client Fax.

Please see ADDENDUM for Genetic Information Nondiscrimination Act. DO NOT PROVIDE GENETIC Information.

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Addendum to Attending Provider Statement

IMPORTANT NOTICE REGARDING GINA

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 employees or their family members. In order to comply with this law, we are asking that you do 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.