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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: ______________________________