ReedGroup

Behavioral Health Provider's Statement of Work Capacity and Impairment: Initial

Return completed form to PO Box 6278, Broomfield, CO 80021 or Fax to 1-847-554-1853

Note: Your patient has informed ReedGroup that you would be willing to submit clinical information to support his/her disability claim. Please note that sections 4, 5, and 6 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.

In accordance with the federal law, GINA, [Genetic Information Nondiscrimination Act of 2008], please do not provide us with any genetic information. More information about GINA is included on the Authorization form [employee/patient] presented to you.

Patient Information	First Name:	Last Name:	Claim Number:
	Date of Birth _____/_____/_____	Gender: ☐ Male ☐ Female	
Vocational Information	Employer:	Job Title:	Date of Hire:
	Intellectual Skills Demand of Job: ☐Unskilled ☐Semi-skilled ☐Skilled ☐Highly Skilled		
Claim Information	First day of absence: _____/_____/_____	Definition of Disability: ☐Own Job ☐Own Occupation ☐Any Occupation	
	Claim Manager:	Phone # & Ext:	Fax Number:

1. Nature of Treatment

Date of first office visit:	**Date of last office visit:**	**Next office visit:**

Primary Disabling Diagnosis: _____ **DSM/ICD Code:** _____

Relevant Co-Morbid Conditions/Disorders: _____ **DSM/ICD Code:** _____

_____ **DSM/ICD Code:** _____

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: _____/_____/_____

Psychotropic Medications:

Name:	Name:	Name:
Dosage:	Dosage:	Dosage:
Frequency:	Frequency:	Frequency:
Start Date: _____/_____/_____	Start Date: _____/_____/_____	Start Date: _____/_____/_____

Medication side effects: ☐ None ☐ Present; describe: _____

☐ Other health care providers currently treating and/or scheduled to treat the patient for their behavioral health disorder:

Provider's Name: _____ Phone: _____ Specialty: _____
Provider's Name: _____ Phone: _____ Specialty: _____

2. Patient's Report of Work Impairment and Residual Capacity:

My patient reported the following description of his/her symptoms and associated work impairment(s) and residue work capacity:

_____

_____

Health Care Provider's Initials:	**Date:**

Return completed form to PO Box 6278, Broomfield, CO 80021 or Fax to 1-847-554-1853

Patient Name:	Claim Number:	Date sent to Provider:

3. Treating Provider's Work Capacity Determination

Did you recommend to your patient to stay home from work due to his/her psychiatric/psychological disorder?
☐ No. If no, please provide a full duty work release per section #8 (Return to Work Status & Plan).
☐ Yes, starting on the following date _____/_____/_____. If yes, please answer the following 3 questions and sections 4 - 9.

1.) When is the estimated return to work date?_____/_____/_____ If you cannot predict an estimated return to work date at this time, do you support the employee to be out of work until their next appointment date listed above? [See section #1 "Next Office Visit"] ☐ Yes ☐ No

2.) Please provide your rationale for recommending disability leave by referencing your behavioral observations, and provocative mental status exam findings supporting functional impairment(s) that precluded your patient from performing work. Please be sure to explain how your patient's illness impacted his capacity to perform the social and/or intellectual demands of his/her job per the definition of disability noted above. If the disability 'test" is noted to be "Any Occupation" please explain how his/her illness precludes any work which would include work at an unskilled level.

_____
_____
_____

3.) Do you **currently** consider your patient to be totally impaired as of your patient's last office visit noted in section #1 above? ☐ Yes ☐ No, explain

_____
_____

4. Affect Modulation: Clinician Observed Appropriateness and Control

Upon examination, it is my opinion that my patient's ability to modulate his/her affect at work is:
☐ Within Normal Limits → Proceed to Section #5a (Behavioral Functioning-Clinician Report).
☐ Impaired → complete the following Affect Modulation subsections before advancing to section 5a.

Please Provide Detailed Behavioral Observations if Impairment is Reported.

- Affect displayed during exam (Describe affect intensity and appropriateness: ☐WNL ☐Impaired as evidenced by the following:

  _____
  _____

- Ability to compose self and display appropriate affect within the context of work setting: ☐WNL ☐Impaired, Explain below.

  _____
  _____

- Panic Attacks and/or Anxiety Features impact work capacity: ☐Not Applicable ☐Yes, please specify parameters below.

  Primary Symptoms experienced: 1.) _____ 2.) _____ 3.) _____ 4.) _____

  Additional Symptoms experienced: 1.) _____ 2.) _____ 3.) _____

  Frequency of panic attacks (e.g. per day/week/month): _____

  Average Duration of each panic attack: _____

5a. 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 #5b (Behavioral Realm of functioning -Self Report of Activities of Daily Living).
☐ Impaired → complete the following Behavioral Functioning subsection (a) before advancing to section 5b.

- Psychomotor activity and ability to apply effort: ☐WNL ☐Impaired, describe: _____

  _____

Presented with appropriate dress and hygiene in session? ☐Yes ☐No, describe:_____

Impulse Control

- Substance abuse, Compulsive behavior, Manic or Hypomanic features: ☐WNL ☐Impaired, describe_____

  _____

- Suicidal ideations present that impact work capacity: ☐Not applicable ☐Yes, explain_____

  _____

- Aggressiveness, Irritability, and/or Homicidal ideations that impact work capacity: ☐Not applicable ☐Yes, explain_____

  _____

Health Care Provider's Initials:	Date:

Return completed form to PO Box 6278, Broomfield, CO 80021 or Fax to 1-847-554-1853

Patient Name:	Claim Number:	Date sent to Provider:

5b. Behavioral Functioning: Self Report of Activities of Daily Living

- Recent weight loss or gain ☐ Not Applicable ☐Yes, note weight change in specified amount of time _____
- Sleep disturbances: ☐ Not Applicable · ☐Yes, indicate average hours of sleep per night _____
- Cleans/Maintains residence: ☐Yes · ☐No Performs routine shopping: ☐Yes ☐No Pays bills: ☐Yes ☐ No
- If no to any of the 3 items above, describe impairment_____
- Socialization problems: ☐No · ☐Yes, describe_____
- Operates a motor vehicle: ☐Yes ☐No, explain_____
- Currently participates in: ·☐Volunteer work ☐Self-employed work of a lesser demanding level than current job ☐Assisting with care of a handicapped family member or friend ☐Other additional activities_____

6. Cognitive Functioning

Upon examination, it is my opinion that my patient's ability to provide appropriate and sufficient cognitive effort at work is:

☐ Within Normal Limits → Proceed to Section #7 (Barriers to Returning to Work).
☐ Impaired → complete the following cognitive functioning subsections before advancing to Section #7.

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:

- Serial 7's subtractions from 100: _____, _____, _____, _____, _____, _____ OR serial 3's from 20: _____, _____, _____, _____, _____, _____
  (93) (86) (79) (72) (65) (58) (17) (14) (11) (8) (5) (2)

☐ Not assessed ☐Other assessment technique results_____

_____

Comprehension:

- Able to follow a three step command: ☐Not assessed ☐Yes ☐No, Exam Findings_____
- Able to read a paragraph of text and report the main concept/idea of the passage: ☐Not assessed ☐Yes
  ☐No, Describe results_____
- Other measurement(s) _____

Memory Functions:

- Digit Recall forward: ____ ____ ____ ____ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
  7 5 1 3 4 6 7 1 8 3 0 8 4 1 2 6

- Digit Recall backwards: (The numbers should be presented to the claimant at a one second cadence. After the string of numbers is read aloud the claimant should repeat the digits back to the examiner in reverse order, e.g. "5-3-9" presented, correct response from claimant would be "9-3-5".

  ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
  5 3 9 1 6 2 0 8 4 1 2 6

- Recall of 4 unrelated words (e.g. house, ball, tree, and car) presented orally after 5 minutes_____, 10 minutes_____, and 30 minutes_____.
- Other measurements or observations of memory functions:

_____

Language Skills:

- Delusional ideations expressed: ☐ No ☐Yes, describe:_____
- Speech: ☐within normal limits, ☐ Impaired, describe:_____

_____

- Thought Organization & Content: ☐Within normal limits ☐ Impaired, describe:_____

_____

Executive Functioning:

- Reasoning, Judgment, and Self-regulation ☐ WNL, ☐ Impaired, describe: _____

Health Care Provider's Initials:	Date:

Return completed form to PO Box 6278, Broomfield, CO 80021 or Fax to 1-847-554-1853

Patient Name:	**Claim Number:**	**Date sent to Provider:**

Perceptual Disturbances:

- Orientated to: ☐Person, ☐Place, ☐Time, ☐and Situation. If disturbance is noted please describe, _____

_____

- Hallucinations or Dissociative episodes: ☐ Not Applicable ☐ Self-reported ☐ Clinician observed claimant experiencing

Describe if symptoms are present_____

7. Additional Factors Impacting a Return to Work

My Patient has reported the following which may influence my patient's willingness to return to work:

☐Not Applicable, ☐Recent increase in work demands ☐Conflict with supervisor

☐ Recent unfavorable work evaluation ☐Anticipation of relapse if returned to current work demands ☐General dissatisfaction with job

☐Overburdened with the care of a handicapped adult or special needs child.

If any of the factors listed above are identified, or if a non-listed issue has been identified, please describe_____

_____

8. Return to Work Status & Plan

My patient's work status is as follows:

☐ Released to full duty on _____/_____/_____

☐ Released to temporary modified duty as described below on _____/_____/_____ and to full duty as of _____/_____/_____

Please operationalize your prescribed restrictions/accommodation by providing measurable parameters e.g. able to return 20 hours per week the 1st week, as well as providing a clinical rationale, e.g. to decrease risk of panic attacks within the first week of work as patient's first panic attack was triggered by a specific work demand. _____

_____

☐ I am unable to release my patient at this time. My estimated date for my patient's release to work is _____/_____/_____.

Do you anticipate, or currently recommend, permanent work restrictions? ☐No ☐Yes, explain_____

9. Teleconference:

At some point in time, if your patient's work capacity is unclear, the current claim manager may ask an independent consulting Psychologist or Psychiatrist to review the file and call you to clarify the patient's severity of illness and functional capacity. Would you be willing to participate in a brief (5 to 10 minute) teleconference?

☐No ☐Yes, preferably on the following days of the week and approximate time slots:

Day(s) of the week: _____ Hours of the Day_____

Additional Comments:

Health Care Provider's Name (Print)	**Specialty**	**Degree**	**Tax ID #:**
Address (Street No., City, State, Zip Code)	**Phone**	**Fax**	
Signature		**Date**	