

# METLIFE's BEHAVIORAL HEALTH INITIAL FUNCTIONAL ASSESSMENT FORM

NAME: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ SSN: \_\_\_\_\_

CLAIM#: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

PROVIDER'S NAME: \_\_\_\_\_ BOARD CERTIFIED SPECIALTY: \_\_\_\_\_

PROVIDER'S SIGNATURE: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ FAX NUMBER: \_\_\_\_\_

MANAGED CARE AFFILIATION FOR THIS CLIENT: \_\_\_\_\_

CURRENT DSM-IV AXES	CURRENT ICD 9 CODE	CURRENT DSM-IV DESCRIPTION (PLEASE DESIGNATE ACUTE OR CHRONIC)
AXIS I: CLINICAL DISORDERS		
AXIS II: PERSONALITY DISORDERS		
AXIS III: GENERAL MEDICAL CONDITIONS		
AXIS IV: PSCHOSOCIAL & ENVIRONMENTAL		
AXIS V: GAF SCORES	Initial Score (and Date)	Most Recent Score (and Date)

When did the patient first experience psychiatric symptoms?	
What were the precipitating events that lead to the patient's initial visit with you? Provide Date first seen.	
Describe the patient's primary targeted psychiatric symptoms <u>as reported to you.</u>	
Describe the patient's primary targeted psychiatric symptoms <u>as observed by you.</u>	
Is ETOH or CD abuse suspected or impacting the treatment response? How has this been ruled in or ruled out?	
Describe the current treatment regimen and frequency i.e., CBT/ Pharmacotherapy (only)/Family Therapy /Psychodynamic /Other	

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<p><b>Describe current medications/ Dosages/Frequency Blood levels if relevant.</b></p>	
<p><b>Has this patient exhibited any suicidal or homicidal intent that would create a threat to themselves or to co-workers? Dates when this was assessed?</b></p>	
<p><b>Previous Hospitalizations:</b></p>	
<p><b>Describe your patient's response to the current treatment regimen.</b></p>	
<p><b>Describe the patient's ability to complete his/her ADL's. Dates when assessed?</b></p>	
<p><b>What changes if any are being considered to further optimize your patient's treatment response?</b></p>	
<p><b>Is a Return To Work (RTW) an index of wellness in your ongoing assessment of clinical improvement for this patient?</b></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/> (Please explain why not)</p>
<p><b>What specific symptoms, deficits, or functional impairments are prohibiting the individual from returning to his/her job?</b></p>	
<p><b>Please address how the current treatment plan actively addresses the above impairment?</b></p>	
<p><b>Please provide a prognosis/estimated date for return to work (Part-Time or Full-Time).</b></p>	
<p><b>Please specify reasonable accommodations and the expected duration that would facilitate a re-entry into the work place.</b></p>	
<p><b>Could this patient perform the <u>same</u> job in a different location or division of the company?</b></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/> (Please explain why not)</p>
<p><b>Could this patient currently perform the <u>same</u> job at a different company?</b></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/> (Please explain why not)</p>