



sedgwick

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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 <input type="checkbox"/> No <input type="checkbox"/> | _____           | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____         |
| _____      |      |           |          | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____           | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____         |
| _____      |      |           |          | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____           | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____         |

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: \_\_\_\_\_