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Attending Physician's Statement
of Continued Disability for Mental Health

Please print or type

Patient Name: Social Security No.: Date of Birth: Employer:

Patient Address: City: State: ZIP Code:

I hereby authorize release of information on this form by the below named physician for the purpose of claim processing.

Signed: Date:

To be completed by the Attending Physician - Use current information from your patient's most recent examination or office visit to complete this form. (The patient is responsible for the completion of this form without expense to the company.)

Is the condition related to environmental and /or interpersonal issues in his/her workplace? Yes No If yes, explain:

If yes, can he/she perform the same job at a different location/employer? Yes No

Are these issues causing a disincentive to return to work with current employer? Yes No

DIAGNOSIS DSM-IV MULTI AXIAL AND ICD-9 CODES

Axis I: (Please supply ICD-9 code on line supplied) ICD-9 Code:

Axis II: (Please supply ICD-9 code on line supplied) ICD-9 Code:

Axis III: Axis IV:

Axis V: Current GAF Score: Past Year GAF Score:

Does the patient have a psychiatric history? Yes No (If yes, attach details)

Self-reported symptoms:

Observed symptoms (change from baseline, frequency, duration, severity):

Are the symptoms severe enough to impact social/occupational functioning? Yes No If yes, explain how:

Medications (indicate any changes):

Are medications in therapeutic range? Yes No If no, are there any anticipated changes? (Note Plan)

RETURN TO WORK PLAN/FUNCTIONALITY (This information is required for evaluation of your patient's claim for disability benefits).

Is your patient able to return to work without accommodations? Yes No If yes, Full time Part time

Date: Hours per day:

If no, provide examples of accommodations that would allow him/her to engage in social/occupational activities:

Is your patient able to return to work with accommodations? Yes No If yes, Full time Part time

Date: Hours per day:

If able to return to work only part time, on what date will he/she be able to increase to full time?

How long are these work accommodations expected to be in place? (Attach clinical information to support this duration.)

TREATMENT

Date you first treated this patient for this condition: Frequency of treatment:

Date of last office visit: Date of next scheduled office visit:

Hospitalization since last report? Yes No If yes, name of hospital:

Admission date: Discharge date:

Has patient been referred to other physicians/therapists? Yes No If yes, date of referral(s):

Referral provider name: Phone number: Specialty:

PHYSICIAN INFORMATION

Provider's name: Phone number:

Street address: City: State: ZIP Code:

Degree: Specialty: License number:

Fax number: Social Security or EIN number:

Signature: Date signed: