



# Behavioral Health Clinician Statement

Client Name	Provider Name	Clinical Manager
Client Date of Birth	Provider Telephone Number	Clinical Manager Telephone Number
Client Case Number	Provider Fax Number	Clinical Manager Fax Number

Provide detailed examination findings that would prohibit the claimant from performing.

Any  Own: Occupation as

## A. Clinician's Perspective

1. Have you recommended to your Client to stay home from work?  Yes, on the following date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 No, I have not recommended to be off from work.

2. If you answered Yes to question #1, please provide your rationale for recommending disability leave:

## B. Cognitive Functioning

1. Able to write a sentence from your dictation?  Yes  No, exam findings:

2. Able to follow a three step command?  Yes  No, exam findings:

3. Able to read a narrative paragraph from a magazine or newspaper and report the main concept/idea of the passage?  Yes  No

4. Able to perform five operations of serial 7's or 3's?  Yes  No, exam findings:

5. Memory Functions:

Digit span forward = \_\_\_\_  Digit span backwards = \_\_\_\_  4 unrelated words after 5 minutes

Other measurement(s)

6. Applied focus and concentration in session for periods of:

30-50 min.  15-30 min.  5-10 min.  less than 5 min.

7. Expressed his/her current circumstances and responded to direct questions appropriately?  No  Yes

If No, was redirection needed? Please describe:

8. Reasoning and/or Judgment:  within normal limits  impaired, please describe:

9. Delusional ideation evident?  No  Yes, please describe:

10. Hallucinations reported?  No  Yes, please describe:

## C. Emotional Functioning

1. Emotional state during exam (Describe affect type, range, intensity, lability and congruency with content discussed).

2. Able to spontaneously compose her/himself?  Yes  No, please explain:

3. Panic attacks?  No  Yes, please specify below:

a. Symptoms experienced: \_\_\_\_\_

b. Frequency of panic attacks: \_\_\_\_\_

c. Duration of each attack: \_\_\_\_\_

## D. Behavioral Observations

1. Behaviors observed during exam:

2. Psychomotor activity and ability to apply effort:  Unremarkable  Impaired, please describe:

3. Presented with appropriate dress and hygiene in session?  Yes  No, please describe:

4. Impulse Control (e.g. substance abuse, manic behavior, aggressive behavior):

Speech:  Slurred  Pressured  Stammering  Loud  Soft  Over Productive  Under Productive

Other: \_\_\_\_\_

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**E. Risk to Self/Others**

1. Suicidal ideation?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, please describe if plan reported:
2. Homicidal ideation?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, please describe if plan reported:
3. Has the claimant contracted for safety?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If no, please describe:
4. Able to report reasons for not harming self/others?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If no, please describe:

**F. Client Self Report of Activities of Daily Living**

1. Is client currently performing:	<input type="checkbox"/> Volunteer Work	<input type="checkbox"/> Attending School	<input type="checkbox"/> Self-Employed
	<input type="checkbox"/> Work at a Lesser Demanding Job	<input type="checkbox"/> No Work Activities in Any Capacity	
2. Significant weight/appetite changes?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, please describe:	
3. Sleep disturbances?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, please describe:	
4. Socialization problems?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, please describe:	
5. Cleans/Maintains residence? <input type="checkbox"/> Yes <input type="checkbox"/> No	6. Performs routine shopping? <input type="checkbox"/> Yes <input type="checkbox"/> No	7. Pay bills? <input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Operates a motor vehicle?	<input type="checkbox"/> Yes <input type="checkbox"/> No, please explain:		

**G. Treatment**

	Start Date	End Date	Days Per Week	Hours Per Day	Frequency	Last Visit	Next Visit
<input type="checkbox"/> Inpatient Care			N/A	N/A	N/A	N/A	N/A
<input type="checkbox"/> Partial Hospitalization Programs						N/A	N/A
<input type="checkbox"/> Intensive Outpatient (IOP)						N/A	N/A
<input type="checkbox"/> Outpatient Psychotherapy	N/A	N/A	N/A	N/A			
<input type="checkbox"/> Medication Management	N/A	N/A	N/A	N/A			
1. Current medications/changes in medication:							
2. Medication side effects: <input type="checkbox"/> No <input type="checkbox"/> Yes, please describe side effects:							

**G. Diagnostic Impressions**

Axis I: _____	Axis III: _____	Axis V: Global Assessment of Functioning:
Axis II: _____	Axis IV: _____	Current _____
		Prior to Work Leave _____

**H. Work Status**

1. <b>Client's perspective:</b> The client has conceptualized the following barriers in returning to work:		
<input type="checkbox"/> Increase in work demand	<input type="checkbox"/> Conflicts with supervisor	<input type="checkbox"/> Anticipation of relapse
<input type="checkbox"/> Recent unfavorable work evaluation	<input type="checkbox"/> Dissatisfaction with the job	<input type="checkbox"/> Other: _____

**I. Claimant Return To Work Status**

<input type="checkbox"/> Released to work full duty on ____/____/____	<input type="checkbox"/> Unable to work at this time. Projected return to work by ____/____/____
<input type="checkbox"/> Able to work with modifications: Please list: _____	

Signature	Exam Report Date	Date Form Completed
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