**Member Name:** _________________________________  
**Member ID #:** __________________________________

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**PSYCHIATRIC & FUNCTIONAL ASSESSMENT**
**MANAGED DISABILITY PROGRAM**

Please phone & fax your assessment within 24 hrs  
Tel 800.817.5042      Fax 866.895.1454

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### PRECIPITATING EVENT (Why Is Client Requesting Time Off Work At This Time?)

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### CLINICAL PRESENTATION (In the CLIENT’S OPINION, What Psychiatrically/Psychologically Prohibits Her/Him From Working At This Time?)

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**Assessor Observations:**  
☑ On time for session  ☐ Drove self to session  ☐ Driven to interview by ____________  
☐ Cooperative in session  ☐ Participated in session alone  ☐ Participated in session with ____________

---

### CURRENT PSYCHIATRIC SYMPTOMS (List ONLY Symptoms That Are CURRENTLY Present)

<table>
<thead>
<tr>
<th></th>
<th>Reported by Client</th>
<th>Observed in Interview</th>
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<tbody>
<tr>
<td></td>
<td>Mild</td>
<td>Mod</td>
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<tr>
<td><strong>Mood/Affect</strong></td>
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<td><strong>Thought Process</strong></td>
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<td><strong>Behavior</strong></td>
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**Duration:**

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### MENTAL STATUS

<table>
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<tr>
<th><strong>Orientation</strong></th>
<th>Yes</th>
<th>No</th>
<th><strong>Cognition</strong></th>
<th>Yes</th>
<th>No</th>
<th>If &quot;No,&quot; then list details:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alert?</td>
<td>☐</td>
<td>☐</td>
<td>Formal Thought Intact?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Person?</td>
<td>☐</td>
<td>☐</td>
<td>Speech/Language Intact?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Place?</td>
<td>☐</td>
<td>☐</td>
<td>General Knowledge Intact?</td>
<td>☐</td>
<td>☐</td>
<td></td>
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</tbody>
</table>
**Mental Status—Continued**

### Appearance
- [ ] Well kept & groomed
- [ ] Adequate
- [ ] Disheveled
- **Appropriate Eye Contact?**
  - [ ] Yes
  - [ ] No

### Other Mental Status Problems

### Overall Mental Status
- [ ] WNL
- [ ] Mildly Impaired
- [ ] Moderately Impaired
- [ ] Severely Impaired

### Current Risk Factors

#### Suicidality
- [ ] None
- [ ] Ideation
- [ ] Plan
- [ ] Intent
- [ ] Means
- [ ] Gesture

#### Homicidality
- [ ] None
- [ ] Ideation
- [ ] Plan
- [ ] Intent
- [ ] Means
- [ ] Gesture

#### Impulse Control
- [ ] Sufficient
- [ ] Moderate
- [ ] Minimal
- [ ] Inconsistent
- [ ] Explosive

If risk exists, did client contract not to harm self?  
- [ ] Yes
- [ ] No

Contract not to harm others?  
- [ ] Yes
- [ ] No

**Details of Risk:**

#### Abuse (Physical or Sexual) and/or Neglect
- [ ] Yes
- [ ] No

If "Yes", client is:  
- [ ] Victim
- [ ] Perpetrator
- [ ] Both
- [ ] Neither, but abuse exists in client’s current living situation

Abuse or neglect involves a child or elder?  
- [ ] Yes
- [ ] No

Legally Reported?  
- [ ] Yes
- [ ] No

**Details:**

#### Substance Abuse/Chemical Dependency (Specify Substance, Quantity, Frequency, Date Last Used, Abuse/Dependence/In Remission, Family History)
- [ ] Client denies

**CAGE-AID**  
(Score (1 to 4):  
(Scoring the CAGE-AID: Score 1 point for each positive response. A score of 2 or greater indicates the need for further evaluation.)

Time period of current abstinence:  
- [ ] None
- [ ] Other

Current withdrawal symptoms/blackouts/DTs?  
- [ ] Yes
- [ ] No

If "Yes," specify:

Substance abuse related problems?  
- [ ] Occupational
- [ ] Family/Home
- [ ] Educational
- [ ] Financial
- [ ] Legal

### Past Psychiatric Treatment

**Current Psychiatric Medications (Names, Dosages, and Dates Initially Prescribed)**  
- [ ] None

Prescribed by:  

- [ ] Psychiatrist
- [ ] Other:

Does client comply with psychiatric medication regimen?  
- [ ] Yes
- [ ] No

**Medical History (Condition, Year Diagnosed, Medications, Name of Medications Prescriber)**  
- [ ] None

### Home Functioning

Marital Status:  

Currently Living:  
- [ ] Alone
- [ ] With Family/Others

Social supports available?  
- [ ] Yes
- [ ] No

Sleep:  
- [ ] Adequate
- [ ] Disturbed (describe):
Member Name: _________________________________  Member ID #: ___________________________________

**Appetite:** [ ] Adequate  [ ] Disturbed (describe):

**How are the client’s days structured while s/he is off work (e.g., activities, household chores, daily tasks, self-care)?**

**OTHER STRESSORS THAT MIGHT EXACERBATE CLIENT’S DIFFICULTIES IN WORKING (Check all that apply)**

- [ ] Disabled Family Members
- [ ] Educational Problem
- [ ] Environmental
- [ ] Family Illness
- [ ] Financial Problems
- [ ] Health Care
- [ ] Housing
- [ ] Legal Problems
- [ ] Marital/Relationship Problems
- [ ] Social

**DIAGNOSES (Include DSM-IV-TR Five-Digit Alphanumeric Diagnostic Codes; List ALL FIVE Axes)**

<table>
<thead>
<tr>
<th>Axis I:</th>
<th>1°:</th>
<th></th>
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<tbody>
<tr>
<td></td>
<td>2° (if present):</td>
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<tr>
<td></td>
<td>3° (if present):</td>
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<tr>
<td>Axis II:</td>
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<td>Axis III:</td>
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<tr>
<td>Axis IV:</td>
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<tr>
<td>Axis V:</td>
<td>Current GAF:</td>
<td>Highest GAF during in past 12 months:</td>
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</table>

**FUNCTIONAL ASSESSMENT**

Is the member able to perform Activities of Daily Living?  [ ] Yes  [ ] No  If “No,” specify reasons for inability:

Is the member able to comprehend and follow instructions?  [ ] Yes  [ ] No  If “No,” specify reasons for inability:

Is the member able to perform simple and repetitive tasks?  [ ] Yes  [ ] No  If “No,” specify reasons for inability:

Is the member able to maintain an appropriate work pace?  [ ] Yes  [ ] No  If “No,” specify reasons for inability:

Is the member able to relate appropriately to others beyond giving and receiving instructions?  [ ] Yes  [ ] No  If “No,” specify reasons for inability:

**ASSESSOR’S RECOMMENDATIONS**

**Client’s Psychological/Psychiatric Ability to Work (Please Select ONE Of the Following Two Choices):**

- [ ] Client’s psychological/psychiatric symptoms **DO NOT IMPAIR** her/his ability to perform her/his primary job tasks appropriately and effectively at this time.

- [ ] Client’s psychological/psychiatric symptoms **IMPAIR** her/his ability to perform her/his primary job tasks appropriately and effectively at this time.

**Rationale:**

**Treatment Recommendations:**
<table>
<thead>
<tr>
<th>Name</th>
<th>Phone #</th>
<th>Date Client Assessed</th>
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<tbody>
<tr>
<td>Signature</td>
<td>Date</td>
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</table>

ASSESSOR INFORMATION

Member Name: _________________________________   Member ID #: _________________________________