**PSYCHIATRIC & FUNCTIONAL ASSESSMENT**
**MANAGED DISABILITY PROGRAM**
Please phone & fax your assessment within 24 hrs
Tel 800.817.5042      Fax 866.895.1454

<table>
<thead>
<tr>
<th>PRECIPITATING EVENT (Why Is Client Requesting Time Off Work At This Time?)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CLINICAL PRESENTATION (In the CLIENT’S OPINION, What Psychiatrically/Psychologically Prohibits Her/Him From Working At This Time?)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>CURRENT PSYCHIATRIC SYMPTOMS (List ONLY Symptoms That Are CURRENTLY Present)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reported by Client</strong></td>
</tr>
<tr>
<td>Mood/Affect</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Thought Process</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Behavior</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MENTAL STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Orientation</strong></td>
</tr>
<tr>
<td>Alert?</td>
</tr>
<tr>
<td>Person?</td>
</tr>
<tr>
<td>Place?</td>
</tr>
<tr>
<td><strong>Cognition</strong></td>
</tr>
<tr>
<td>Formal Thought Intact?</td>
</tr>
<tr>
<td>Speech/Language Intact?</td>
</tr>
<tr>
<td>General Knowledge Intact?</td>
</tr>
</tbody>
</table>
**MENTAL STATUS—Continued**

<table>
<thead>
<tr>
<th>Appearance</th>
<th>Well kempt &amp; groomed</th>
<th>Adequate</th>
<th>Disheveled</th>
<th>Appropriate Eye Contact?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Other Mental Status Problems**

**Overall Mental Status**

<table>
<thead>
<tr>
<th></th>
<th>WNL</th>
<th>Mildly Impaired</th>
<th>Moderately Impaired</th>
<th>Severe Impaired</th>
</tr>
</thead>
</table>

**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 substance abuse/chemical dependency issues

**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 (specify): ____________________________

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 (specify): ____________________________

Social supports available?  
- Yes
- No

If Yes, who?  

Sleep:  
- Adequate
- Disturbed (describe): ____________________________
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</th>
<th>Diagnosis</th>
</tr>
</thead>
</table>
| I    | 1°: __________
|      | 2° (if present): __________
|      | 3° (if present): __________
| II   | __________
| III  | Economic Problems
|      | Educational Problems
|      | Housing Problems
|      | Occupational Problems
|      | Other psychosocial and environmental problems
| IV   | Problems related to interaction with legal system/crime
|      | Problems related to the social environment
|      | Problems with access to health care services
|      | Problems with primary support group
| V    | Current GAF: __________
|      | Highest GAF during in past 12 months: __________

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: _____________________________________________________________________
### ASSESSOR INFORMATION

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