**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>mood/affect</td>
<td></td>
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**mental status**

<table>
<thead>
<tr>
<th></th>
<th>yes</th>
<th>no</th>
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<tbody>
<tr>
<td>alert?</td>
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<tr>
<td>person?</td>
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<td>place?</td>
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<thead>
<tr>
<th></th>
<th>yes</th>
<th>no</th>
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<tbody>
<tr>
<td>cognition</td>
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<thead>
<tr>
<th></th>
<th>yes</th>
<th>no</th>
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<tbody>
<tr>
<td>formal thought intact?</td>
<td></td>
<td></td>
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<tr>
<td>speech/language intact?</td>
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<tr>
<td>general knowledge intact?</td>
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</tbody>
</table>
Time?  
Details:  
Simple Calculations Intact?  
Serial Sevens Intact?  

MENTAL STATUS—Continued

Appearance  
Details:  
Appropriate Eye Contact?  

Other Mental Status Problems

Overall Mental Status  

CURRENT RISK FACTORS

Suicidality  
Homicidality  
Impulse Control  
If risk exists, did client contract not to harm self?  
Contract not to harm others?  

Details of Risk:

Abuse (Physical or Sexual) and/or Neglect  
If “Yes”, client is:  
Abuse or neglect involves a child or elder?  
Legally Reported?  

Details:

Substance Abuse/Chemical Dependency (Specify Substance, Quantity, Frequency, Date Last Used, Abuse/Dependence/In Remission, Family History)  

CAGE-AID  
Score (1 to 4):  

Time period of current abstinence:  
Current withdrawal symptoms/blackouts/DTs?  
Substance abuse related problems?  

PAST PSYCHIATRIC TREATMENT

CURRENT PSYCHIATRIC MEDICATIONS (Names, Dosages, and Dates Initially Prescribed)  

Prescribed by:  

Does client comply with psychiatric medication regimen?  

MEDICAL HISTORY (Condition, Year Diagnosed, Medications, Name of Medications Prescriber)  

HOME FUNCTIONING

Marital Status:  
Currently Living:  
Social supports available?  
Sleep:  

UBH Managed Disability Program 03/2012  
PROPERTY OF UBH  
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BH1487
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>1°:</th>
<th>2° (if present):</th>
<th>3° (if present):</th>
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<tbody>
<tr>
<td>Axis II:</td>
<td></td>
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<tr>
<td>Axis III:</td>
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Axis IV:
- Economic Problems
- Educational Problems
- Housing Problems
- Occupational Problems
- Other psychosocial and environmental problems
- 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

Axis 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: __________________________
<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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**ASSESSOR INFORMATION**

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