Member Name: ______________________ Member ID #: ______________________

PSYCHIATRIC & FUNCTIONAL ASSESSMENT
MANAGED DISABILITY PROGRAM

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

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

____

____

____

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

____

____

____

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)

	Reported by Client			Observed in Interview			
	Mild	**Mod**	**Severe**	**Mild**	**Mod**	**Severe**	**Duration**
Mood/Affect							
__________	☐	☐	☐	☐	☐	☐	__________
__________	☐	☐	☐	☐	☐	☐	__________
__________	☐	☐	☐	☐	☐	☐	__________
__________	☐	☐	☐	☐	☐	☐	__________
Thought Process							
__________	☐	☐	☐	☐	☐	☐	__________
__________	☐	☐	☐	☐	☐	☐	__________
__________	☐	☐	☐	☐	☐	☐	__________
__________	☐	☐	☐	☐	☐	☐	__________
Behavior							
__________	☐	☐	☐	☐	☐	☐	__________
__________	☐	☐	☐	☐	☐	☐	__________
__________	☐	☐	☐	☐	☐	☐	__________
__________	☐	☐	☐	☐	☐	☐	__________

MENTAL STATUS

Orientation	Yes	No	**Cognition**	Yes	No	If "No," then list details:
Alert?	☐	☐	Formal Thought Intact?	☐	☐	__________
Person?	☐	☐	Speech/Language Intact?	☐	☐	__________
Place?	☐	☐	General Knowledge Intact?	☐	☐	__________

Member Name: ______________________ Member ID #: ______________________

Time?	☐	☐	Simple Calculations Intact?	☐	☐	
Details:			Serial Sevens Intact?	☐	☐	

MENTAL STATUS—Continued

Appearance ☐ Well kempt & groomed ☐ Adequate ☐ Disheveled

Details:

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** 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):

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)

Axis I: 1°: ____________________

2° (if present): ____________________

3° (if present): ____________________

Axis II: ____________________

Axis III: ____________________

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: ____________________

Member Name: ________________________________ Member ID #:__________________________________

ASSESSOR INFORMATION		
Name	Phone #	Date Client Assessed
Signature		Date