**Please fax the completed form to:**
**Fax Number: 833-357-5153**
**The Hartford**
**P.O. Box 14869**
**Lexington, KY 40512-4869**
**Email: GBInformationUpload@thehartford.com**

# Mental Health Attending Physician's Statement

**TO BE COMPLETED BY THE PROVIDER**

(The patient is financially responsible for this form)

THE HARTFORD

| Patient Last Name: | Patient First (or Preferred) Name: | Date of Birth: | Claim ID Number: |
|---|---|---|---|
| _____ | _____ | _ _/_ _/_ _ _ _ | _____ |
| **Provider Name:** | **Provider Specialty:** | **Phone:** | **Fax/Email:** |
| _____ | _____ | _____ | _____ |

**Please provide all medical records regarding your treatment of the patient for the impairment reported within this report form.**

Is the condition related to environmental and/or interpersonal issues in his/her workplace? ☐ Yes ☐ No

If Yes, explain: _____

If Yes, can he / she perform the same job at a different location/employer? ☐ Yes ☐ No

If Yes, as of what date? _ _/_ _/_ _ _ _
MM DD YYYY

Are these issues causing disincentive to return to work with the current employer? ☐ Yes ☐ No

## Diagnosis

Primary Condition _____ DSM or ICD Code |__||__||__|.|__||__||__||__|

Secondary Condition _____ DSM or ICD Code |__||__||__|.|__||__||__||__|

Current Self-Reported Symptoms _____

_____

## Current Mental Status Examination

Examination Date _ _/_ _/_ _ _ _
MM DD YYYY

| Category | Description | | | | |
|---|---|---|---|---|---|
| Appearance | ☐ Well Groomed | ☐ Disheveled | **If different than baseline, explain:** _____ | | |
| Attitude | ☐ Cooperative | ☐ Guarded | ☐ Suspicious | ☐ Uncooperative | ☐ Belligerent |
| Speech | ☐ Normal | ☐ Halted | ☐ Pressured | ☐ Slurred | ☐ Incoherent |
| Thought Process | ☐ Logical/Coherent | ☐ Tangential | ☐ Circumstantial | ☐ Flight of Ideas | ☐ Perseveration |
| Mood | ☐ WNL | ☐ Depressed | ☐ Anxious | ☐ Irritable | ☐ Euphoric |
| Affect | ☐ Congruent | ☐ Incongruent | ☐ Blunted | ☐ Flat | ☐ Labile |
| Insight into Illness | ☐ Absent | ☐ Fair | ☐ Good | | |
| Psychomotor Activity | ☐ WNL | ☐ Agitation | ☐ Retardation | | |
| Reasoning and Judgment | ☐ WNL | ☐ Impaired | | | |
| Attention | ☐ Intact | ☐ Impaired | ☐ Mild | ☐ Moderate | ☐ Severe |
| Concentration | ☐ Intact | ☐ Impaired | ☐ Mild | ☐ Moderate | ☐ Severe |
| Memory | ☐ Intact | ☐ Impaired | ☐ Mild | ☐ Moderate | ☐ Severe |

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**Current Mental Status Examination** (continued)

Please identify how attention, concentration and/or memory impairments are being measured.

_____

_____

Additional observed symptoms (clinical presentation, frequency) _____

_____

Indicate how this is a change from the patient's baseline. If the condition is chronic or long term, what and when did change occur? _____

_____

**Activities of Daily Living** – Please provide input on the patient's current ability to perform the following:

| | | | | |
|---|---|---|---|---|
| The patient is currently capable of performing: | ☐ Volunteer work<br>☐ Less demanding job | | ☐ Attending school<br>☐ No work in any capacity | ☐ Self-employed |
| Significant weight/appetite change | ☐ Yes | ☐ No | Pounds gained _____<br>Pounds lost _____ | Time period _____ |
| Sleep disturbances | ☐ Yes | ☐ No | Describe _____ | |
| Socialization | ☐ Yes | ☐ No | Describe _____ | |
| Household chores | ☐ Yes | ☐ No | Describe _____ | |
| Routine shopping | ☐ Yes | ☐ No | Describe _____ | |
| In your opinion, is the patient competent to endorse checks, and direct the user of proceeds thereof? | ☐ Yes | ☐ No | Describe _____ | |
| Drivers or operates a vehicle | ☐ Yes | ☐ No | Describe _____ | |
| Caring for self/others | ☐ Yes | ☐ No | | |

Are the impairments impacting the patient's overall global functioning? If so, please explain.

_____

Additional comments on ability to complete daily activities: _____

_____

_____

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# Mental Health Attending Physician's Statement

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Patient Last Name: _____ Patient First (or Preferred) Name: _____ Date of Birth: _ _/_ _/_ _ _ _ Claim ID Number: _____

## Functionality

Are you recommending the patient stop working due to their current symptoms? ☐ Yes ☐ No

If Yes, Begin Date: _ _/_ _/_ _ _ _ (MM DD YYYY)

Are the symptoms of such severity to preclude the patient from social / occupational functioning? ☐ Yes ☐ No

If Yes, when did the symptoms become severe enough to preclude social / occupational functioning? _ _/_ _/_ _ _ _ (MM DD YYYY)

If Yes, what work activities are impaired and how? _____

_____

What is the return to work date you have discussed with the patient? _ _/_ _/_ _ _ _ (MM DD YYYY) ☐ Full-time ☐ Part-time

If Part-time, please specify: Hours per day _____ Days per week _____

What date will the patient be able to increase to full time? _ _/_ _/_ _ _ _ (MM DD YYYY)

If appropriate, provide examples of accommodations that would allow the patient to return to work:

_____

_____

What are the patient's current abilities? What type of work can the patient perform?

_____

_____

Additional comments: _____

_____

## Treatment

Date of onset of disability _ _/_ _/_ _ _ _ (MM DD YYYY) Date you first treated the patient for any condition _ _/_ _/_ _ _ _ (MM DD YYYY)

Date of onset of this condition _ _/_ _/_ _ _ _ (MM DD YYYY) Date you first treated the patient for <u>this</u> condition _ _/_ _/_ _ _ _ (MM DD YYYY) Frequency of treatment _____

List of relevant treatment dates _____

Date of last office visit _ _/_ _/_ _ _ _ (MM DD YYYY) Date of next office visit _ _/_ _/_ _ _ _ (MM DD YYYY)

Has the patient been referred to any other mental health providers/physicians? ☐ Yes ☐ No

If Yes, please provide the following information:

Provider Name _____ Phone: ( _ _ _ ) _ _ _ - _ _ _ _

Provider Address _____

Are you coordinating care with this provider? ☐ Yes ☐ No

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Patient Last Name: _____ Patient First (or Preferred) Name: _____ Date of Birth: _ _/_ _/_ _ _ _ Claim ID Number: _____

## Treatment (continued)

Was the patient hospitalized or treated at a higher level of care for this condition? ☐ Yes ☐ No

If Yes, please provide information about any higher level of care:

**Inpatient**

Hospital/Facility Name _____ Phone: ( _ _ _ ) _ _ _ - _ _ _ _

Admission date _ _/_ _/_ _ _ _ (MM DD YYYY) Discharge date _ _/_ _/_ _ _ _ (MM DD YYYY) Reason for inpatient admission _____

**Partial Hospital/Day Treatment/IOP**

Hospital/Facility Name _____ Phone: ( _ _ _ ) _ _ _ - _ _ _ _

Admission date _ _/_ _/_ _ _ _ (MM DD YYYY) Discharge date _ _/_ _/_ _ _ _ (MM DD YYYY) Days per week _____ Hours per day _____

**Residential**

Hospital/Facility Name _____ Phone: ( _ _ _ ) _ _ _ - _ _ _ _

Admission date _ _/_ _/_ _ _ _ (MM DD YYYY) Discharge date _ _/_ _/_ _ _ _ (MM DD YYYY) Days per week _____ Hours per day _____

Medication (dose, change, date of change) _____

Response to medication (including any side effects) _____

Status (please check one) ☐ In remission ☐ Improved ☐ Unchanged ☐ Retrogressed

Please provide a description of the most significant recent improvement and / or decompensation

## Provider Information

Provider Name: _____ License Number: _____

Specialty: _____ Degree: _____ Phone: ( _ _ _ ) _ _ _ - _ _ _ _

Address: _____ Fax: ( _ _ _ ) _ _ _ - _ _ _ _

Email: _____

Office Contact: _____ Contact Phone: ( _ _ _ ) _ _ _ - _ _ _ _

Provider Signature: _____ Date: _ _/_ _/_ _ _ _ (MM DD YYYY)