

**4. ICD-9 Diagnosis**

**DSM Diagnosis**

_____	Axis I Clinical
_____	Axis II Developmental & Personality
_____	Axis III Physical Conditions
_____	Axis IV Psychosocial Stressors
Pregnancy EDC / /	Axis V Global Functioning

Objective Findings (Clinical, X-ray, EKG, LAB, Tests): \_\_\_\_\_

**5. Psychosocial**

- a. Describe any significant events in the employee's past or recent history (including when): \_\_\_\_\_
- b. What are the employee's current supports? \_\_\_\_\_
- c. What are the employee's current activities? \_\_\_\_\_
- d. Is the spouse employed?  Yes  No Spouse's Occupation \_\_\_\_\_  
 Has the illness interfered?  Yes  No If Yes, please describe: \_\_\_\_\_
- e. Has the employee lost contact with friends or family?  Yes  No

**6. Treatment**

First Visit \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Visit \_\_\_\_/\_\_\_\_/\_\_\_\_ Frequency \_\_\_\_\_

List all medications \_\_\_\_\_

Has patient been hospital confined?  Yes  No Confined from \_\_\_\_/\_\_\_\_/\_\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_

If Yes, give name and address of hospital \_\_\_\_\_

**7. Prognosis**

Has the employee made significant progress? If No, explain \_\_\_\_\_

What changes do you expect in the near future? \_\_\_\_\_

**8. Return to Work Plan**

What work duties can employee perform? \_\_\_\_\_

What duties can employee not perform? \_\_\_\_\_

What changes would allow employee to work:

Own job? _____	When? _____
Job Modification? _____	When? _____
Trial work? _____	When? _____
Part-time? _____	When? _____
Any other job? - Type of work _____	When? _____

What steps has the employee taken to return to work? \_\_\_\_\_

Could the employee work while receiving treatment? If No, why not? \_\_\_\_\_

Names of other Treating Physicians/Consultants	Specialty	Address	Phone No.
_____	_____	_____	_____
_____	_____	_____	_____

Do you feel the patient is competent to endorse checks and direct the use of the proceeds?  Yes  No

Physician's Name (please type or print) \_\_\_\_\_

Board Certified/Eligible: \_\_\_\_\_ # \_\_\_\_\_

Office Address \_\_\_\_\_ Phone Number(\_\_\_\_) \_\_\_\_\_

Degree/Specialty \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date Completed \_\_\_\_/\_\_\_\_/\_\_\_\_