aetna®

Behavioral Health Clinician Statement

Aetna Life Insurance Company
Fax #: 1-866-667-1987

Patient Name	Provider Name	Clinical Manager Name
Patient Year of Birth	Provider Telephone Number	Clinical Manager Telephone Number
Patient Case Number	Provider Fax Number	Clinical Manager Fax Number 1-866-667-1987

Patient Occupation:

Do you currently support your patient being out work? ☐ *Yes* ☐ *No*

Diagnostic Impressions

Primary Diagnosis(es) Preventing Work (DSM V Code)	Mild	Moderate	Severe	Other Specifiers

Patient's Current Progress: ☐ Improved ☐ Stable ☐ Regressed

The patient has expressed the following barriers in returning to work:

☐ Increase in work demand ☐ Conflicts with supervisor ☐ Anticipation of relapse ☐ Recent unfavorable work evaluation
☐ Dissatisfaction with the job ☐ Medication complications ☐ Medical/Physical Complications ☐ Other: _____

Risk to Self/Others

1. Current suicidal ideation?	☐ Yes	☐ No	If Yes, please describe plan/intent:
2. Current homicidal ideation?	☐ Yes	☐ No	If Yes, please describe plan/intent:
3. Have you and the patient agreed upon measures to be taken should the threat to harm self/others become imminent?	☐ Yes	☐ No	If Yes, please describe:
4. Is the patient able to report reasons for not harming self/others?	☐ Yes	☐ No	If Yes, please describe:

Emotional Functioning

1. Emotional state/mental status during exam (Describe affect, mood, range, lability, congruency with content).
2. If the patient was tearful, was it appropriate to the content being discussed? ☐ Yes ☐ No, please explain:
3. Requires assistance to compose self? ☐ Yes ☐ No If Yes, please describe:
4. Panic attacks? ☐ Yes ☐ No
   a. Symptoms reported: _____
   b. Frequency of panic attacks/Duration of each attack: _____
   c. Intervention used: _____
   d. Panic attack ever observed in exam?: ☐ Yes ☐ No If Yes, please describe:

Additional Examination Findings/Notes

_____
_____
_____

Patient Name	Provider Name	Clinical Manager Name

Cognitive Functioning

1. Able to follow a three step command? ☐ Yes ☐ No, please provide exam details:
2. Able to perform five operations of Serial 7's or 3's? ☐ Yes ☐ No, please provide exam details:
3. Memory Functions: ☐ Digit span forward = _____ ☐ Digit span backwards = _____ ☐ 4 unrelated words after 5 minutes
   ☐ Other measurement(s) _____
4. Applied focus and concentration in session for periods of: ☐ 30-50 min. ☐ 15-30 min. ☐ 5-10 min. ☐ less than 5 min.
5. Expressed his/her current circumstances and responded to direct questions appropriately? ☐ Yes ☐ No, please describe
6. Reasoning and/or Judgment: ☐ Within normal limits ☐ Impaired, please describe:
7. Are psychotic symptoms present? (Delusions, hallucinations) ☐ Yes ☐ No If Yes, please describe:
8. Was a mini mental status exam completed? ☐ Yes ☐ No If Yes, please provide score:

Additional Examination Findings/Notes

Behavioral Observations

1. Behaviors observed during exam. Please provide specific details.
2. Psychomotor activity: ☐ Unremarkable ☐ Impaired, please describe:
3. Presented with appropriate dress and hygiene in session? ☐ Yes ☐ No, please describe:
4. Difficulty with impulse control? ☐ Yes ☐ No Please describe:
5. Speech: ☐ Normal ☐ Slurred ☐ Pressured ☐ Stammering ☐ Loud ☐ Soft ☐ Over Productive ☐ Under Productive

Additional Examination Findings/Notes

Activities of Daily Living

1. Is patient currently performing: ☐ Volunteer Work ☐ Attending School ☐ Self-Employed
   ☐ Work at a Lesser Demanding Job ☐ No Work Activities in Any Capacity
2. Significant weight/appetite changes? ☐ Yes ☐ No Gain/loss within _____ (Time frame)
3. Sleep disturbances? ☐ Yes ☐ No Please describe:
4. Socialization problems? ☐ Yes ☐ No Please describe:
5. Cleans/Maintains residence? ☐ Yes ☐ No
   Performs routine shopping? ☐ Yes ☐ No
   Pays bills? ☐ Yes ☐ No
6. Is patient able to safely operate an automobile or other motorized vehicle? ☐ Yes ☐ No, please describe:
7. What does your patient do on a daily basis?

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Treatment

	Start Date	End Date	Days Per Week	Frequency	Last Visit	Next Visit
☐ Inpatient Care						
☐ Partial Hospitalization Programs						
☐ Intensive Outpatient (IOP)						
☐ Outpatient Psychotherapy						
☐ Medication Management						

Medications

1. Please list all current medications.
2. Any recent changes in medications? ☐ Yes ☐ No If Yes, please describe:
3. Medication side effects? ☐ Yes ☐ No If Yes, please describe:

Additional Examination Findings/Notes.

Referrals

1. Have you referred your patient to any other providers? ☐ Yes ☐ No If Yes, please provide name and contact information:
2. Have you recommended that your patient stay home from work on disability? ☐ Yes ☐ No
3. Please specify the recommended Start Date ____/____/____ End Date ____/____/____

Claimant Return To Work Status

1. Is your patient:
   ☐ Able to return to work FULL DUTY without modification. Full Duty release to return to work date: _____
2. If your patient is not returning to work to his/her occupation, what capacity does he/she have to work at a different occupation?
3. What are the tasks related to your patient's occupation that he/she is able to perform at this time?
4. Can your patient volunteer or work part time? ☐ Yes ☐ No If Yes, please indicate volunteer or part time with start date, number of hours per day, days per week, and duration of the limitations and restrictions. Please provide any other modifications for your patient to return to work.
5. Can your patient participate in vocational rehabilitation counseling? ☐ Yes ☐ No, please explain.

Please attach the most recent office notes

Signature/Exam Date

Signature	Date Exam Completed
Print Name	Date Form Completed
Credentials	

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individuals' family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. ***Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.***