**DISABILITY AND LEAVE**

**HEALTH CARE PROVIDER STATEMENT**

**Return to Sedgwick**

**Email: ChevronMail@sedgwick.com | Fax: 855-800-5116 | PO Box 14648, Lexington, KY 40512 | Phone: 1-888-825-5247**

**Patient Name: <Employee Name>**

**Claim Number: <File Number>**

**Due Date: <Medical Due Date>**

**To Be Completed by Health care Provider (Type or Print)**

**Section 1: Required Information to Support FMLA/State Leave**

1. Will the patient be incapacitated for a single continuous period of time due to their medical condition, including any time for treatment and recovery? Yes 🞎 No 🞎
If yes, estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_- \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_
2. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? Yes 🞎 No 🞎
If yes, dates of admission:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Date(s) you treated the patient for condition:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. When is the patient’s next office visit? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
5. Was medication, other than over-the-counter medication prescribed? Yes 🞎 No 🞎
6. Is the medical condition pregnancy? Yes 🞎 No 🞎 If yes, expected delivery date:\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_
7. Is the patient unable to perform any of their job functions due to their condition: Yes 🞎 No 🞎
If yes, identify the job functions the employee is unable to perform (use the list of the employee’s essential functions or job description, if included, or answer this question based upon the patient’s own description of their job functions).
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Describe other relevant medical facts, if any, other than genetic information (see GINA discussion below), related to the condition for which the patient seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment).

*DO NOT INCLUDE DIAGNOSIS IF PATIENT IS IN CA OR CT*
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 2: Required Information to Support Disability Benefits**

The patient’s current disability plan requires that medical information indicate an inability to perform the essential duties of their own job.

Patient’s occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you recommended to your patient to stay home from work? [ ]  Yes [ ]  No If yes, effective what date? \_\_\_/\_\_\_\_/\_\_\_\_

Provide your rationale for recommending the patient stay home from work. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Can your patient return to work with accommodations? [ ]  Yes [ ]  No If yes, effective what date? \_\_\_\_\_/\_\_\_\_\_/\_\_\_

Describe accommodations:

Your patient will be released to work full duty on: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

**Support your opinion with the following information:**

**(Attach all office notes, history & physical, results of x-rays, laboratory tests, MRI Reports, etc., if relevant)**

**DIAGNOSIS**

Primary: ICD Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_

Secondary: ICD Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_

**COGNITIVE FUNCTIONING EVALUATION**

Applied focus and concentration in session for periods of:

[ ]  30 to 50 minutes [ ]  15 to 30 minutes [ ]  5 to 10 minutes [ ]  less than 5 minutes

Concentration: [ ]  Within normal limits [ ]  Impaired If impaired, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Decision Making: [ ]  Within normal limits [ ]  Impaired If impaired, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expressed their current circumstances and responded to direct questions appropriately: [ ]  Yes [ ]  No

If No, was redirection needed? [ ]  Yes [ ]  No Please describe:

Reasoning and/or Judgment:[ ]  Within normal limits [ ]  Impaired If impaired, describe:

Delusional ideations evident: [ ]  Yes [ ]  No If yes, describe:

Hallucinations reported: [ ]  Yes [ ]  No If yes, describe:

Memory functions: Four (4) unrelated words after five (5) minutes: Other testing results:

Able to perform five operations of serial 7’s or 3’s: [ ]  Yes [ ]  No

Exam findings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Able to carry out verbal instructions given during exam? [ ]  Yes [ ]  No

If no, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Able to carry out written directions given during exam? [ ]  Yes [ ]  No

If no, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Able to read a narrative paragraph from a magazine or newspaper and report the main concept/idea of the passage:

 [ ]  Yes [ ]  No

**EMOTIONAL FUNCTION AND BEHVAIORAL OBSERVATIONS**

Date of last exam: Behavior(s) and emotional state observed during exam:

Able to spontaneously compose themself: [ ]  Yes [ ]  No If no, explain:

Psychomotor activity and ability to apply effort: [ ]  unremarkable [ ]  Impaired If impaired, describe:

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Presented with appropriate dress and hygiene in session: [ ]  Yes [ ]  No If no, describe:

Impulse control: [ ] Physical abusive behavior [ ]  Verbal abusive behavior [ ] Substance abuse/addiction [ ] Alcohol abuse/addiction [ ] Manic behavior

Speech: [ ]  Slurred [ ]  Pressured [ ]  Stammering [ ]  Loud [ ]  Soft [ ]  Over productive [ ]  Under productive

 [ ]  Other (please describe)

Risk to self/others:

Suicidal Ideations: [ ]  Yes [ ]  No Plan reported: [ ]  Yes [ ]  No If yes, explain:

Homicidal Ideations:[ ]  Yes [ ]  No Plan reported: [ ]  Yes [ ]  No If yes, explain:

Able to report reasons for not harming self/others: [ ]  Yes [ ]  No If no, explain:

Contracted for safety: [ ]  Yes [ ]  No If no, explain:

**PATIENT SELF REPORT OF ACTIVITIES OF DAILY LIVING**

Is the patient currently performing any of the following:

[ ]  Volunteer work [ ]  Works at a lesser demanding job [ ]  Attending school [ ]  No work activities in any capacity

[ ]  Self-employment

Has the patient conceptualized the following areas as barriers in returning to work:

[ ]  Increase in work demands [ ]  Conflicts with supervisor [ ]  Anticipation of relapse

[ ]  Recent unfavorable work evaluation [ ]  Dissatisfaction with the job [ ]  Other (specify)

Has the patient expressed or are you aware that they are experiencing any psychosocial stressors? [ ]  Yes [ ]  No If yes, describe:

Significant weight changes: [ ]  Yes [ ]  No Current weight: ­­­\_ Previous weight: Date of previous weight:

Significant appetite changes: [ ]  Yes [ ]  No If yes, describe diet:

Significant sleep disturbance:[ ]  wakes more than twice per night [ ]  sleeps less 4 hours or less [ ]  sleeps 12 hours or more

Are any of the above weight, appetite, or sleep disturbances related to medication side effects? [ ]  Yes [ ]  No If yes, please describe:

Panic attacks: [ ]  Yes [ ]  No Specify below:

* Frequency of panic attacks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Duration of panic attacks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Symptoms experienced during panic attacks:

Socialization problems: [ ]  Yes [ ]  No If yes, describe:

Is patient able to: Clean/maintain residence: [ ]  Yes [ ]  No

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Perform routine shopping: [ ]  Yes [ ]  No Pay bills: [ ]  Yes [ ]  No

Operate motor vehicle: [ ]  Yes [ ] No If no to any of these, explain:

**TREATMENT**

Date initiated care: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Inpatient care: Date(s) of hospitalization: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Partial hospitalization programs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date(s) of care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Intensive outpatient (IOP): Start date:\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ End date:\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

 Days per weeks: Hours per day:

Outpatient psychotherapy: Frequency: Date of next visit: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Medication management: Frequency: Date of next visit: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Current medications/changes in medication; list all medications and identify dates of new medications or dose adjustments: (attach list if necessary)

 Medication Dose Frequency Duration New Medication Date prescribed Adjusted Medication Date Adjusted

 Yes 🞎 No 🞎 \_\_\_\_\_\_\_\_\_\_ Yes 🞎 No 🞎 \_\_\_\_\_\_\_\_\_\_

 Yes 🞎 No 🞎 \_\_\_\_\_\_\_\_\_\_ Yes 🞎 No 🞎 \_\_\_\_\_\_\_\_\_\_

 Yes 🞎 No 🞎 \_\_\_\_\_\_\_\_\_\_ Yes 🞎 No 🞎 \_\_\_\_\_\_\_\_\_\_

Medication side effects: [ ]  Yes [ ]  No If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Attach all office notes, History & Physical, etc., if relevant.**

“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, information about the manifestation of a disease or disorder in an individual’s family members, the fact that an individual or an individual’s family member sought or received genetic services (including genetic testing, counseling, or education), or participated in clinical research  which includes such 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.”

**Health care Provider Information (Required):**

|  |  |  |  |
| --- | --- | --- | --- |
| National Provider Identifier (NPI):  |  | Provider Specialty: |  |
| Telephone Number:  |  | Fax Number:  |  |
| Provider Printed Name: |  |  |  |
| Provider Signature:  |  | Date:  |  |
| Are you related to the patient? |  Yes No | If yes, please specify how you are related |  |