Please fax the completed form to:
Fax Number: 518-869-2317
New York State Nurses Association Benefits Fund
P.O. Box 12-430
Albany, NY 12212

ATTENDING PHYSICIAN'S STATEMENT - PROGRESS REPORT
(For Mental Health Claims)

THE HARTFORD

To Be Completed By The Employee

Patient Name:	Date of Birth:	Insured ID Number:

Patient Address: (Street, City, State & Zip Code)

To be completed by the Provider - Use current information from your patient's most recent office visit or examination to complete this form. *(The patient is responsible for the completion of this form without expense to the company.)*

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

Are these issues causing a disincentive to return to work with current Employer? ☐ Yes ☐ No

DIAGNOSIS:

Primary Condition: _____ DSM or ICD Code: _____

Secondary Condition: _____ DSM or ICD Code: _____

Patient Assessment Measures

WHODAS Score: _____

Domain I_____ Domain II_____ Domain III_____ Domain IV_____ Domain V_____ Domain VI_____

(*Provide completed assessment questionnaire*)

Other Assessment Measures - please list the measure scale and provide score (attach test results):

_____ _____ _____ _____

Current Self Reported Symptoms:

Current Observed Symptoms (*Clinical presentation, frequency, severity, examples):*

CURRENT MENTAL STATUS EXAMINATION
(Please circle or check current status or explain in "Comments")

Examination Date: _____

Category	Description	Comments
Appearance	☐ Well groomed ☐ Disheveled	
Attitude	☐ Cooperative ☐ Guarded ☐ Suspicious ☐ Uncooperative ☐ Belligerent	
Speech	☐ Normal ☐ Halted ☐ Pressured ☐ Slurred ☐ Incoherent	
Thought Process	☐ Logical/Coherent ☐ Tangential ☐ Flight of ideas ☐ Circumstantial	
Mood	☐ WNL ☐ Depressed ☐ Anxious ☐ Irritable ☐ Euphoric	
Affect	☐ Congruent ☐ Incongruent ☐ Blunted ☐ Flat ☐ Labile	
Insight into illness	☐ Absent ☐ Fair ☐ Good	
Psychomotor Activity	☐ WNL ☐ Agitation ☐ Retardation	

		Please check the statement that indicates how this was assessed?
Attention	☐ Intact ☐ Impaired. ☐ mild ☐ moderate ☐ severe	☐ Observed ☐ Tested ☐ Self-Reported
Concentration	☐ Intact ☐ Impaired: ☐ mild ☐ moderate ☐ severe	☐ Observed ☐ Tested ☐ Self-Reported
Memory	☐ Intact ☐ Impaired: ☐ mild ☐ moderate ☐ severe	☐ Observed ☐ Tested ☐ Self-Reported

STATUS *(Please check one):* ☐ In remission ☐ Improved ☐ Unchanged ☐ Retrogressed

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

Patient Name: Date of Birth: Insured ID Number:

FUNCTIONALITY

Did you recommend your patient stop working? ☐ Yes ☐ No If Yes, on what date?

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

If Yes, specify what activities are impaired and how:

What is the expected duration of any work activity impairments?

Have you discussed a return to work goal with your patient? ☐ Yes ☐ No If No, please explain:

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

What is your target date for return to work for your patient? ☐ Full time ☐ Part time

If part time, on what date will your patient be able to increase to full time?

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

Additional comments:

In your opinion is the patient competent to endorse checks and direct the use of the proceeds thereof? ☐ Yes ☐ No

TREATMENT

Current Treatment Plan:

Date you first treated this patient for any condition:	Date you first treated this patient for this condition:
Frequency of treatment	List relevant treatment dates:
Date of last office visit:	Date of next scheduled office visit:

Medications (indicate any changes/adjustments including dosage since last report):

Response to medication:

Has patient been referred to other mental health providers/physicians since last report? ☐ Yes ☐ No

If "yes", are you coordinating care with this provider(s)? ☐ Yes ☐ No Date of Referral(s):

Referral Provider Name	Phone Number: ( )	Specialty:

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

If "yes", please provide information about any higher level of care since last report:

Inpatient: Hospital/facility name Phone Number: ( )

Admission date: Discharge date:

Partial Hospital/Day Treatment/IOP: Hospital/facility name Phone Number: ( )

Admission date: Discharge date: Number of days per week: Number of hours per day:

Residential: Facility name: Phone Number: ( )

Admission date: Discharge date:

PROVIDER'S INFORMATION

Provider's Name:			Telephone number: ( )
Address: (Street, City, State & Zip Code)			Fax Number: ( )
Degree:	Specialty:	Social Security Number or EIN Number:	License Number:
Office Contact:			Office Contact Phone ( )

Provider's Signature: Date Signed: