Return to: P.O. Box 6248
Broomfield, CO 80021
Fax: 720-279-6783
Phone: 888-825-5247, option 5

Behavioral Health Evaluation Form

INSTRUCTIONS: The following evaluation form must be completed by the employee's physician or health care provider. The purpose of this report is to assist us in making a disability determination. Please complete all the applicable sections of this form. You may be requested to provide copies of supporting reports such as office notes, medical records, consultations and/or testing. In all situations, you must complete the signature block at the bottom of this form.

Patient Information		
Name:	Date of Birth:	Employer: **Chevron**

Diagnosis	
ICD-9:	DSM IV:
Primary:	Axis I:
Secondary:	Axis II:
Tertiary:	Axis III:
Other Information:	Axis IV:
	Avis V:

Treatment and Medications	
Date treatment began:	Date of last appointment:
Date of next appointment:	Expected frequency of appointments (daily, weekly, monthly, etc.)

Please check all that apply: ☐ Individual Therapy ☐ Group Therapy ☐ Medication Management

☐ Hospitalization (if hospitalized, please provide details including name and address of hospital, dates of hospitalization, reason for hospitalization and treatment provided. Please also include copies of the admittance and discharge reports:

☐ Other (please explain):

Please list all current medications (attach separate sheet if additional space is needed):

Medication Name	Dosage	Frequency	Date Started	Name of Prescribing Physician (check box if psychiatrist)
				☐
				☐
				☐
				☐

Please indicate any recent changes in medications and the reason for the change:

Treatment goals and estimated duration of treatment to achieve stated goals:

Is patient compliant with all treatment recommendations?
☐ Yes ☐ No (please explain):

Patient Status
Is patient appropriately groomed? ☐ Yes ☐ No (please explain):
Behavior: ☐ Appropriate ☐ Irritable ☐ Belligerent ☐ Other (please explain):
Speech: ☐ Normal ☐ Tangential ☐ Rapid/pressured ☐ Delayed ☐ Monotone ☐ Other (please explain):
Mood: ☐ Appropriate ☐ Depressed ☐ Anxious ☐ Hostile ☐ Euphoric ☐ Agitated ☐ Other (please explain):
Stress level or other factors affecting patient:
Impairment in concentration, thought process or memory? ☐ No ☐ Yes (please explain):
If the patient's work is considered "safety sensitive", do you believe they will have any difficulty in performing their job duties and daily tasks safely? ☐ No ☐ Yes (please explain):
Is the patient oriented to person, place and time? ☐ Yes ☐ No (please explain):
Historical or current alcohol / substance abuse issues or concerns: ☐ No ☐ Yes (please explain):
Does the patient have suicidal or homicidal ideation? ☐ No ☐ Yes (please explain):

Return To Work	
Dates patient has been unable to work: From: Through:	Estimated return to work date: Part-Time/Partial-Duty: Full-Time/Full-Duty:
Current Restrictions (activities patient should not do) and Limitations (activities patient cannot do):	
How will you determine when the patient is ready to return to work in any capacity?	

Provider's Signature (please attach any and all documentation which support your findings and opinions)	
Signature	Date:
Printed Name:	Specialty:
Phone:	Fax: