DEPARTMENT OF ADMINISTRATIVE SERVICES
STATEMENT OF PSYCHIATRIC DISABILITY ADM4316

EMPLOYEE: Section A (Employee, complete this section before giving the form to your provider)

_____ _____
Patient's Name (Please Print) Disability Claim Number

AUTHORIZATION: I hereby authorize any hospital or clinic, physician, nurse or practitioner, including my health plan, the State's mental health vendor, Optum, the Employee's Assistance Program (EAP), the Bureau of Workers' Compensation, the retirement system which I participate in or any other person, office or provider with knowledge of my illness, injury or condition to provide the Ohio Department of Administrative Services (DAS) or its representative and State agencies involved with my return to work or claim for disability benefits with complete information as to my health and medical history, eligibility for Disability Retirement Benefits and any information required in connection with this claim, hereby waiving any and all privileged character of such information. I also hereby authorize DAS or its representative to release any such information it receives to my health plan, the State's mental health vendor, Optum, the Employee Assistance Program (EAP), the Bureau of Workers' Compensation, the retirement system which I participate in and State agencies involved with my return to work or claim for disability benefits. I understand my health plan, the State's mental health vendor, Optum, State agencies or other party acting as a representative for the State may contact me regarding their services in assisting me to return to work. A photocopy of this authorization shall be valid as the original. I understand that it is my responsibility under the Americans with Disabilities Act to contact my employer if I wish to apply for reasonable accommodations under ADA or to obtain information about my rights under ADA.

_____ _____
(Patient Signature) (Date)

This authorization will be valid for 18 months from date of signature. I understand, that I have the right to revoke this authorization at any time prior to its expiration by providing written notice to the Disability Unit for the Ohio Department of Administrative Services, 30 East Broad Street, 27th Floor, Columbus, Ohio 43215. However, I understand, that I may not revoke any action taken by DAS in reliance on this authorization prior to the date DAS receives my written notice of revocation. Additionally, I understand that revoking this authorization may impair further processing of my claim or result in my claim being discontinued.

TREATMENT PROVIDER SECTION: Section B
(Employee is prohibited from completing any portion of this section)

NOTE TO TREATMENT PROVIDER: Please complete the following questions as thoroughly as possible. Failure to do so may result in a denial of your patient's benefits. Any cost for completion of this report is your patient's responsibility.

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 individual's 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.

1. Date rendered disabled. _____

2. DSM diagnostic code, with symptomology. _____
_____
_____

3. Please include interpretive results of MMPI or other psychological testing if done. _____
_____
_____

4. Provide dates of treatment. _____
_____
_____

5. List medications, changes in medications with dates changed, any side effects from medication and lab results.
_____
_____
_____

6. Describe patient's mood and affect. _____
_____
_____

7. Comment on patient's ability to carry out daily activities and follow instructions. _____
_____
_____

7. Describe patient's behavior or any changes in behavior. _____
_____
_____

8. Is there any evidence of a thought disorder? Please comment. _____
_____
_____

9. Comment on patient's judgment and ability to concentrate. _____
_____
_____

10. Is there any impairment in memory? Please comment. _____
_____
_____

11. Has patient been referred to another treatment source? If so, please provide name, address and copy of evaluation, if available. _____
_____
_____

12. Comment on how the combined symptoms and intensity interfere with job performance. _____
_____
_____

13. Plan of treatment toward return to work with expected date of return. _____
_____
_____

14. Patient's condition prevents them from working:

☐ Temporarily ☐ Permanently ☐ For longer than 12 months

15. If disability is temporary, patient's estimated date of release to return to work:

_____ For regular occupation Mo. _____ Day _____ Yr. _____

_____ On a part-time basis Mo. _____ Day _____ Yr._____

Part-time schedule: hours per day _____ days per week _____ # of weeks _____

_____ For suitable work activities within the limitations listed above Mo. _____ Day _____ Yr._____

Name (treatment provider) Please Print		Specialty	Federal ID #
Street Address, City, State, ZIP Code			
Telephone (area code)	Fax (area code)	Email Address	
Date form received	Date signed	Signature	