OHIO INDUSTRIAL COMMISSION
MENTAL AND BEHAVIORAL HEALTH
SPECIALIST REPORT

INJURED WORKER NAME:
DATE OF BIRTH:
CLAIM NUMBER(S):
DATE(S) OF INJURY:
CLAIM ALLOWANCE(S):
DISALLOWED CONDITION(S):

This information can be found on the Medical Scheduling Worksheet and/or the Statement of Facts and must be listed exactly as provided.
Do NOT include Social Security number.

PLACE OF EXAMINATION:
DATE OF EXAMINATION:
DATE OF ERPORT:
EXAMINER NAME:

Your examiner information.

PURPOSE OF EXAMINATION: The purpose of the examination was discussed at the request of the Ohio Industrial Commission in response to the Injured Worker's application for permanent total disability, that I would be providing a written report to the Ohio Industrial Commission and that the results of this examination are not confidential. I explained that I would not be providing the Injured Worker with any type treatment or advice.

HISTORIAN:

ALSO PRESENT DURING EXAMINATION:

DESCRIPTION OF INJURED WORKER:

HISTORY:

REVIEW OF RECORDS: I have reviewed all records provided to me by the Industrial Commission.

This statement encompasses the Medical Scheduling Worksheet, Statement of Facts, Referral letter, and the Specialist Packet.

CHIEF COMPLAINT:

HISTORY OF PRESENT CONDITION:
(*In this area include: description of injury, job duties at the time, treatment, response to treatment, current treatment, treatment plan)*

REVIEW OF PAST TREATMENT:

CURRENT TREATMENT:

MEDICATIONS:

MENTAL HEALTH HISTORY:

In each section, provide a summary with information from your exam and your review of the medical records provided.

Provide a claim identifier (claim #, Injured Worker's name) and page number on every page to ensure we have received your complete report.

PAST MEDICAL HISTORY:

FAMILY OF ORIGIN AND PROCREATION:

EDUCATION:

WORK HISTORY:

LEGAL HISTORY:

MILITARY HISTORY:

SUBSTANCE USE AND ABUSE:

In each section, provide a summary with information from your exam and your review of the medical records provided.

MENTAL STATUS EXAMINATION:

APPEARANCE:

ATTITUDE:

BEHAVIOR:

MOOD AND AFFECT:

SPEECH:

PERCEPTUAL DISTURBANCES:

THOUGHT PROCESS: (*quantity, tempo and form*)

THOUGHT CONTENT: (*delusions, hallucinations, obsessions, and phobias*)

COGNITION: (*alertness, orientation, attention, memory, language, and executive function*)

INSIGHT:

JUDGMENT:

This is your examination, report all pertinent positive and negative findings

Claim #:
IW Name:

REVIEW OF FOUR FUNCTIONAL AREAS:

ADL/TYPICAL DAY:

SOCIAL FUNCTIONING:

CONCENTRATION, PERSISTENCE, AND PACE:

ADAPTATION:

It is important to compare/contrast the pre-injury and the post-injury activities and abilities to fully convey the injury's effect on the functional capabilities.

In each section, provide a percentage of impairment and the corresponding class level.

REVIEW OF TESTING: *(If applicable)*

MULTIAXIAL DIAGNOSIS:

GAF VALUE:

Provide complete DSM-IV multiaxial diagnosis and GAF value.

OPINIONS:

1. **Has the Injured Worker reached maximum medical improvement with regard to the allowed condition(s)? If "no", describe the rationale for your opinion and disregard items #2 and #3. If "yes", describe the rationale for your opinion and complete items #2 and #3.**

   - **Provide your answer regarding MMI status with supporting rationale.**
   - **Note: If you opine NOT at MMI, please provide proper rationale according to State of Ohio definitions.**

2. **Based on the AMA Guides, Second and Fifth Editions, and with reference to the Industrial Commission Medical Examination Manual, provide the class and percentage of impairment due to the allowed mental and behavioral condition(s) in each of the four functional areas, as well as, the percentage of whole person impairment. If there is no impairment for an allowed condition, indicate 0%.**

   ADL/TYPICAL DAY: %
   SOCIAL FUNCTIONING: %
   CONCENTRATION, PERSISTENCE, AND PACE: %
   ADAPTATION: %

   WHOLE PERSON IMPAIRMENT: %

Whole Person Impairment should always be expressed as a whole number.

3. **Summarize the Injured Worker's residual mental and behavioral capacity resulting from the impairment associated with the allowed condition(s). Then, complete the enclosed Occupational Activity Assessment.**

   - **Summarize objective findings from your examination and record review that are related to the allowed conditions in the claim.**
   - **Relate these findings to functional deficits or capabilities.**
   - **Cite the corresponding work capacity level.**
   - **If applicable, provide any workplace limitations.**
   - **Completed the Occupational Activity Assessment form.**

_____ _____

(Signature) (Date)