Ohio | Industrial Commission

OHIO INDUSTRIAL COMMISSION
MENTAL AND BEHAVIORAL HEALTH
SPECIALIST REPORT

INJURED WORKER NAME:

DATE OF BIRTH:

CLAIM NUMBER(S):

DATE(S) OF INJURY:

ALLOWED PSYCHOLOGICAL CONDITION(S):

ALLOWED PHYSICAL CONDITION(S):

DISALLOWED CONDITION(S):

To access this information, log into our ICON website where you will find all the records needed for your examination.

This information must be listed exactly as provided on the Medical Scheduling Worksheet and the Statement of Facts .

Examination information

PLACE OF EXAMINATION:

DATE OF EXAMINATION:

DATE OF ERPORT:

EXAMINER NAME:

Prior to the examination, the following was discussed with the injured worker, to explain the purpose and nature of the examination:

- This examination is at the request of the Ohio Industrial Commission, in response the Injured Worker's application for permanent total disability.
- The specialist examiner will be submitting a report to the Ohio Industrial Commission.
- This is not a comprehensive examination. It is focused toward the questions asked by the Ohio Industrial Commission.
- The results of this examination are not confidential. It will be sent to the Ohio Industrial Commission, where the parties to the claim(s) will receive a copy.
- The examining specialist will not be providing the injured worker with any type of treatment or medical advice. There will be no established doctor-patient relationship as a result of this examination.

The injured worker verbalized understanding and agreed to proceed.

Ohio | Industrial Commission

HISTORIAN:

ALSO PRESENT DURING EXAMINATION:

RECORD REVIEW: I have reviewed all of the medical records provided to me by the Ohio Industrial Commission, including but not limited to those referenced in this report. I accept the findings of the examining physicians represented in the medical records provided, however do not necessarily agree with their opinions. I accept all of the allowed conditions in the claim(s).

Who was in the room and who provided the information?

These include the Medical Scheduling Worksheet, Statement of Facts, Referral letter, and the Specialist Packet.

HISTORY OF PRESENT CONDITION:

- **JOB DUTIES AT THE TIME OF INJURY OR INJURIES:**
- **DESCRIPTION OF THE PHYSICAL INJURY:**
- **HISTORY OF DEVELOPMENT OF THE PSYCHOLOGICAL ALLOWANCE:**
- **TREATMENT(S) OF PSYCHOLOGICAL ALLOWANCE(S) AND REPORTED RESPONSE TO TREATMENT:**
- **CURRENT TREATMENT FOR ALLOWED PSYCHOLOGICAL CONDITION(S):**
- **TREATMENT PLAN:**

CURRENT REPORTED PSYCHOLOGICAL SYMPTOMS ARISING FROM ALLOWED CONDITION(S):

MEDICATIONS:

MENTAL HEALTH HISTORY:

MEDICAL CO-MORBIDITIES:

FAMILY OF ORIGIN AND PROCREATION:

EDUCATION:

WORK HISTORY:

LEGAL HISTORY:

MILITARY HISTORY:

HEALTH HABITS:

- **EXERCISE:**
- **DIET:**
- **SUBSTANCE USE:**

HOME LIFE, SOCIAL AND RELATIONAL SUPPORT:

All fields are required.

Ohio | Industrial Commission

All fields are required.

This detailed mental status examination should include the actual responses of the injured worker to specific questions, as well as actual observations of the examiner. Please do not use qualitative terms such as "normal", or "unremarkable".

MENTAL STATUS EXAMINATION:

- OBSERVED APPEARANCE:
  - GAIT:
  - POSTURE
  - CLOTHES:
  - GROOMING:
  - MANNERISMS:
  - GESTURES:
  - PSYCHOMOTOR ACTIVITY:
  - EXPRESSION:
  - EYE CONTACT:
- OBSERVED LEVEL OF CONSCIOUSNESS:
- REPORTED ORIENTATION:
  - PERSON:
  - PLACE:
  - DATE:
  - SITUATION:
- REPORTED MOOD:
- OBSERVED AFFECT:
  - APPROPRIATENESS TO SITUATION:
  - CONSISTENCY WITH REPORTED MOOD:
  - CONGRUENCY WITH THOUGHT CONTENT:
  - FLUCTUATIONS:
  - RANGE:
  - INTENSITY:
  - QUALITY:
- OBSERVED SPEECH
  - QUANTITY:
  - RATE:
  - VOLUME:
  - FLUENCY AND RHYTHM:
- OBSERVED THOUGHT PROCESSES:
- OBSERVED AND TESTED COGNITION:
  - ATTENTION:
  - CONCENTRATION:
  - NAMING:
  - MEMORY AND RECALL:
  - LANGUAGE:
  - ABSTRACTION:
  - VISUOSPATIAL FUNCTION:
  - GENERAL OR CONTEMPORARY KNOWLEDGE:
- OBSERVED OR TESTED INSIGHT:
- OBSERVED OR TESTED JUDGEMENT:

Ohio | Industrial Commission

REVIEW OF PSYCHOLOGICAL TESTING, IF APPLICABLE:

REVIEW AND SUMMARY OF THE FOUR FUNCTIONAL AREAS:

- **ADL, TYPICAL DAY: (CLASS, PERCENTAGE IMPAIRMENT)**
- **SOCIAL FUNCTIONING: (CLASS, PERCENTAGE IMPAIRMENT)**
- **CONCENTRATION, PERSISTENCE, PACE: (CLASS, PERCENTAGE IMPAIRMENT)**
- **ADAPTATION: (CLASS, PERCENTAGE IMPAIRMENT)**

GAF:

Please indicate if the reported test results are computer-generated, and thereby characteristic of persons who have provided similar test response patterns, and; if so, if it is your opinion the results are applicable to and characteristic of the Injured Worker examined

Summarize and review the class and percentage of impairment due to the allowed mental and behavioral conditions in each of the four functional areas.

Ohio | Industrial Commission

Ohio Administrative Code 3121-3-32 states: "'Maximum Medical Improvement' is a treatment plateau (static or well stabilized) where no fundamental functional or physiologic change can be expected within reasonable medical probability, in spite of continuing medical or rehabilitative procedures. An injured worker may require supportive treatment to maintain this level of function."

To support your opinion the Injured Worker was at a treatment plateau at the time of the examination, please indicate if there has been any recent significant change in symptoms, treatment, or function.

Please indicate if you expect any significant change in symptoms, or function in the foreseeable future with current treatment.

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.

Ohio | Industrial Commission

2. Based on the AMA Guides, Fifth Edition, and with reference to the Industrial Commission Medical Examination Manual, provide the class and percentage of whole person 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: (CLASS, PERCENTAGE IMPAIRMENT)
- SOCIAL FUNCTIONING: (CLASS, PERCENTAGE IMPAIRMENT)
- CONCENTRATION, PERSISTENCE, PACE: (CLASS, PERCENTAGE IMPAIRMENT)
- ADAPTATION: (CLASS, PERCENTAGE IMPAIRMENT)
- WHOLE PERSON IMPAIRMENT: (CLASS, PERCENTAGE IMPAIRMENT)

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

Whole Person Impairment must be expressed as a whole number.

CHECK POINTS FOR CONSISTENCY:

What objective examination findings are reasonably associated with the allowed condition(s) and support your opinion?

Are the Injured Worker's subjective reports of symptoms and function consistent with what would reasonably be expected to arise from the allowed conditions, and congruent with your review of records and examination findings?

What findings on review of records support your opinion regarding the severity of the impact and degree of impairment due to the allowed condition(s)?