

The Prudential Insurance Company of America
 Disability Management Services
 PO Box 13480,
 Philadelphia, PA 19176
 Tel: 800-842-1718 Fax: 877-889-4885

Psychiatric Work Readiness Assessment

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| | | | |
|----------------------|----------------------|----------------------|----------------------|
| First Name | MI | Last Name | Claim Number |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

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To Be Completed By Physician

1. Does this employee have work restrictions or limitations due to a psychiatric condition? Yes No

• If **No**, there is no need to complete the remainder of this form. Please sign, date, and fax back to _____ at fax number 877-889-4885.

• If **Yes** and the employee is actively suicidal with intent, actively homicidal, or psychotic, as manifested by the following symptoms _____, please specify your treatment plan _____ and prognosis _____.

Please check the appropriate box above, sign, date, and fax back.

• If **Yes** and the employee is **not** psychotic or actively suicidal/homicidal, please provide the following additional information. Please use specific examples with specific behaviors and dates. In the questions below:

- A **“restriction”** would indicate your recommendation that the employee not perform a specified activity because of risk to self or others.
- A **“limitation”** would indicate your opinion that the employee is not cognitively or otherwise capable of performing a specified activity.
- A **“treatment plan”** should describe in detail treatment methods that specifically target the psychiatric impairment.

2. Is the employee’s absence from work due primarily to discomfort with a specific situation or coworker/supervisor at work?

Yes No

If **Yes**, please give your recommendations for managing this situation.

Please specify your treatment plan for restoring work readiness in this area.

Anticipated date of work readiness in this area _____

If the employee would be able to return to work upon resolution of this situation, there is no need to complete the remainder of this form. Please sign, date, and fax back.

If **No**, please respond to the questions on page 2.

3. Has the employee’s ability to function at work changed from his or her baseline condition while working?

Yes No

If **No**, and the employee’s cognitive function has not changed from previously adequate baseline, please sign, date, and fax back.

If **Yes**, please indicate the clinical evidence for loss of function in your response(s) to one or more of the questions below. Examples of clinical evidence for loss of function could include observations of an employee’s behavior or performance that document the presence of a psychiatric impairment, results of standardized tests, or other corroborative information supporting loss of function.



Psychiatric Work Readiness Assessment, continued

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4. In your clinical opinion, is the employee able to care for himself sufficiently well for return to work (e.g. dressing, hygiene)?
 Yes No

If **No**, please state current restrictions and limitations.

Please specify your treatment plan for restoring work readiness in this area.

Anticipated date of work readiness in this area _____

5. Is the employee able to work in a structured setting? (e.g. specific hours, specific location, timeliness, ability to accept supervision)
 Yes No

If **No**, please state current restrictions and limitations.

Please specify your treatment plan for restoring work readiness in this area.

Anticipated date of work readiness in this area _____

6. Are the employee's social interaction skills adequate for return to work? Yes No

If **No**, please state current restrictions and limitations.

Please specify your treatment plan for restoring work readiness in this area.

Anticipated date of work readiness in this area _____

7. Are the employee's working memory and ability to understand job requirements adequate for return to work?

Yes No

If **No**, please state current restrictions and limitations.

Please specify your treatment plan for restoring work readiness in this area.

Anticipated date of work readiness in this area _____



Psychiatric Work Readiness Assessment, continued

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8. Does the employee have adequate cognitive capabilities to complete assigned tasks (e.g. concentration, persistence, and pace)?
 Yes No

If **No**, please state current restrictions and limitations.

Please specify your treatment plan for restoring work readiness in this area.

Anticipated date of work readiness in this area _____

9. Is the employee sufficiently flexible in thought and behavior to adapt to normal workplace change?
 Yes No

If **No**, please state current restrictions and limitations.

Please specify your treatment plan for restoring work readiness in this area.

Anticipated date of work readiness in this area _____

10. Does the employee have a significant impairment in any other area of cognitive or neuropsychiatric function not addressed in the questions above? Yes No

If **Yes**, please identify the impairment.

Please state current restrictions and limitations.

Please specify your treatment plan for restoring work readiness in this area.

Anticipated date of work readiness in this area _____





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3 Physician Certification

Fraud Notice:

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

I have read and understand the terms and requirements of the fraud warning and I certify the above statements are true.

Physician's Signature: _____ Date

Physician's Printed Name: _____

Specialty

Please FAX this completed document to 1-877-889-4885. Please make sure the claimant's name and claim number are entered at the top of each page. Thank you.

