MENTAL HEALTH REPORT

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

The provision of your Social Security Number (SSN) is mandatory under Wisconsin Statutes 49.145 (2)(k). Your SSN may be verified through computer matching programs and may be used to monitor compliance with program regulations and program management. Your SSN may be disclosed to other Federal and State Agencies for official examination. If you do not provide your social security number, your application for benefits will be denied.

Participant Name	Date of Birth / /	Social Security Number

Name of Professional Provider		Professional Title	
Office Address	City	State	Zip Code

Dear Mental Health Professional,

The individual named above is an applicant/participant in the **Wisconsin Works (W-2)** program. The purpose of this form is to gather information about this individual's current ability to participate in W-2 activities.

W-2 is a program designed to help individuals become self-sufficient through work and work readiness activities. In order to assign appropriate activities, it is important for us to have an idea of what tasks and assignments this individual is capable of. It is also important for us to know about accommodations and modifications that may assist this individual in participating in work readiness activities.

Activities that can be a part of a W-2 placement include:
- o job readiness/life skills workshops;
- o education and job skills training;
- o on-the-job work experience;
- o recommended medical treatments; and
- o counseling and physical rehabilitation activities.

Please answer the following questions concerning this individual's impairments:

1. How frequently is the patient scheduled to meet with you?
   _____

   Regarding current course of treatment, how long have you been meeting with this patient?
   _____

   When is your next scheduled appointment with this patient? _____

2. Are you aware of any other health care professionals who are currently treating this person? If yes, please identify provider name and purpose of treatment: _____
   _____

3. DSM-IV-TR Multiaxial Evaluation:
   - include code and diagnosis for each axis
   - in addition to mental health, please include any diagnosis related to alcohol or other substance abuse

   Axis I: _____ Axis IV: _____

   Axis II: _____ Axis V: Current GAF: _____

   Axis III: _____ Highest GAF Past Year: _____

4. Identify your patient's signs and symptoms associated with this diagnosis:

	Poor Memory		Time or place disorientation
	Appetite disturbance with weight loss		Decreased energy
	Sleep disturbance		Social withdrawal or isolation
	Personality changes		Blunt, flat or inappropriate affect
	Mood disturbance or lability		Illogical thinking or loosening of association
	Pathological dependence or passivity		Anhedonia or pervasive loss of interests
	Delusions or hallucinations		Manic syndrome
	Recurrent panic attacks		Obsessions or compulsions
	Somatization unexplained by organic disturbance		Intrusive recollections of a traumatic experience
	Psychomotor agitation or retardation		Persistent irrational fears
	Paranoia or inappropriate suspiciousness		Generalized persistent anxiety
	Feelings of guilt/worthlessness		Catatonia or grossly disorganized behavior
	Difficulty thinking or concentrating		Hostility and irritability
	Suicidal ideation or attempts		Other:

5. If your patient experiences symptoms which interfere with attention and concentration needed to perform even simple work tasks, during a typical workday, please estimate the frequency of interference. *For this question, "rarely" means 1% to 5% of an eight-hour working day; "occasionally" means 6% to 33% of an eight-hour working day; "frequently" means 34% to 66% of an eight-hour working day; and "constantly" means more than 66% of an eight-hour working day.*

☐ rarely ☐ occasionally ☐ frequently ☐ constantly

Is your patient making positive progress? ☐ Yes ☐ No
Please describe the progress or lack of progress.

_____
_____

6. To the best of your knowledge, is the patient on prescribed medications? ☐ Yes ☐ No
If yes, please list:

_____
_____

Describe any side affects of prescribed medications which may have implications for working, e.g., dizziness, drowsiness, fatigue, lethargy, stomach upset, etc.:

_____
_____

7. When did your patient's symptoms begin (estimate date)?

_____

8. Is it likely that your patient's symptoms will last 6 months or longer? ☐ Yes ☐ No

9. Is it likely that your patient's symptoms will last 12 months or longer? ☐ Yes ☐ No

_____

10. Does the psychiatric condition exacerbate your patient's experience of pain or any other physical symptoms? ☐ Yes ☐ No

If so, please explain:

_____
_____

11. When completing the chart below:

*A "Marked" degree of limitation may arise when several activities or functions are impaired or even when only one is impaired, so long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately and effectively.

**"Concentration, persistence and pace" refers to ability to sustain focused attention sufficiently long to permit the timely completion of tasks commonly found in work settings. This is often evaluated in terms of frequency of errors, assistance required and/or time necessary to complete simple tasks.

*** "Repeated" refers to repeated failure to adopt to stressful circumstances such as decisions, attendance, schedules, completing tasks, interactions with others, etc., causing withdrawal from the stress or to experience decompensation or exacerbation of signs and symptoms.

FUNCTIONAL LIMITATION		DEGREE OF LIMITATION				
1.	Restriction of activities of daily living	None ☐	Slight ☐	Moderate ☐	Marked* ☐	Extreme ☐
2.	Difficulties in maintaining social functioning	None ☐	Slight ☐	Moderate ☐	Marked* ☐	Extreme ☐
3.	Deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner (in work settings or elsewhere) **	Never ☐	Seldom ☐	Often ☐	Frequent ☐	Constant ☐
4.	Episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors)	Never ☐		Once or Twice ☐	Repeated*** ☐	Continual ☐

12. Please describe any additional functional limitations not covered above that would affect your patient's ability to work in a job on a sustained basis: _____
_____

13. On the average, how often do you anticipate that your patient's impairments would become acute so that the patient would be absent from work and other W-2 activities?

☐ Once a month or less
☐ About twice a month
☐ Over twice a month
☐ More than 3 times a month

14. Has there been any recent acute episodes? If yes, please explain and give dates:
_____
_____

15. To determine your patient's ability to do work-related activities on a day-to-day basis in a regular work setting, please give us your opinion – based on your examination – of how your patient's mental/emotional capabilities are affected by the impairment(s). Consider the medical history, the chronicity of findings (or lack thereof) and the expected duration of any work-related limitations, but not your patient's age, sex or work experience.

For each activity shown below, describe your patient's ability to perform the activity according to the following items:

Unlimited to Very Good:	Ability to function in this area is more than satisfactory.
Good:	Ability to function in this area is limited but satisfactory.
Fair:	Ability to function in this area is seriously limited, but not precluded.
Poor or None:	No useful ability to function in this area.

	MENTAL ABILITIES AND APTITUDE NEEDED TO WORK	UNLIMITED TO VERY GOOD	GOOD	FAIR	POOR OR NONE
1.	Interact appropriately with general public				
2.	Understand, remember and carry out very short and simple instructions				
3.	Maintain attention for two-hour segment				
4.	Maintain regular attendance and be punctual with customary, usually strict tolerances				
5.	Sustain an ordinary routine without special supervision				
6.	Work in coordination with or proximity to others without being unduly distracted				
7.	Complete a normal workday and work week without interruptions from psychologically based symptoms				
8.	Perform at a consistent pace without an unreasonable number and length of rest				
9.	Accept instructions and respond appropriately to criticism from supervisors				
10.	Get along with co-workers or peers without unduly distracting them or exhibiting behavioral extremes				
11.	Respond appropriately to changes in a routine work setting				
12.	Deal with normal work stress				
13.	Be aware of normal hazards and take appropriate precautions				
14.	Deal with stress of semi-skilled and skilled work				
15.	Perform detailed or complicated tasks				
16.	Perform fast paced tasks (e.g., production line)				

16. Is the patient attending scheduled appointments? ☐ Yes ☐ No

If no, please explain and list missed appointment dates:

_____

_____

Do you attribute the missed appointments to the mental health impairment? ☐ Yes ☐ No

17. What kind of treatment plan is the patient involved in? What is the expected outcome?

_____
_____
_____

If schedule for treatment plan is known, please include below or attach:

_____
_____

18. Please recommend any other activities and services not included in your treatment plan that may help this individual further address his/her mental health impairment:

☐ Assessment (please specify type) _____

☐ Treatment and counseling (please specify) _____

☐ Advocacy for Social Security Income/Disability

☐ Other _____

19. What type of environment or conditions could help this person function most effectively in a variety of daily activities? _____

_____

20. Considering this patient's mental health condition and limitations please indicate below what activities related to work and training you would recommend?

☐ work/work experience activities	☐ job skills training
☐ adult basic education/literacy	☐ supported job search activities
☐ job readiness/life skills workshops	☐ other _____

If no recommendations, please explain:

_____
_____

21. Estimate the hours a day (5 days a week) this individual can participate in work/work readiness activities within these recommendations? _____

_____

22. Given your patient's current mental impairments, please specify a date when the recommendations that you have provided should be reviewed: _____

Name of Professional Provider	Title	Telephone Number
Signature of Professional Provider		Date Signed

Return completed form to:

Name of Agency Representative		Address		Date Sent
City	State	Zip Code	Telephone Number	Fax Number