

**Mental Health Provider – Mental Status Evaluation**

**Employee Name** \_\_\_\_\_  
**Employer** \_\_\_\_\_

**Statement of Situation: (includes facts, specific quotes, and observable behaviors)**

**Yes**  **No**     **In your professional opinion, does the employee present characteristics that are associated with an increased risk of harm to self or others?**

**(To Provider:** *As an employer, it is essential to ensure the employee's fitness for duty and ability to perform the essential job functions. Please read the below job functions carefully and identify any necessary restrictions. Please be advised that the inability of the employee to perform any or all of the essential functions of their position may result in the employee remaining on medical leave).*

<i>Essential Job Functions</i>	<i>Restriction (Yes or No)</i>	<i>Describe Restriction</i>

I saw this patient on \_\_\_/\_\_\_/\_\_\_ and recommended the following:

- Patient may return to work with **NO** restrictions on \_\_\_/\_\_\_/\_\_\_ or;
- Patient may return to work on \_\_\_/\_\_\_/\_\_\_ with the restrictions described above. If restricted, the duration of these restrictions will be  
     \_\_\_ Permanent      \_\_\_ Time limited to \_\_\_/\_\_\_/\_\_\_  
     The Patient may be re-evaluated on \_\_\_/\_\_\_/\_\_\_
- Patient is **NOT** released at this time to return to work.  
     Next evaluation is scheduled for \_\_\_/\_\_\_/\_\_\_

Provider's Name (Please Print) \_\_\_\_\_ Date \_\_\_\_\_  
 Provider's Signature \_\_\_\_\_ Phone \_\_\_\_\_

(Shaded areas completed by employer)