Psychiatric Independent Medical Examination Report

PATIENT INFORMATION

Name: _____ DOB: _____ dd / mm / yyyy

Claim Number: _____ Date of Evaluation: _____ dd / mm / yyyy

Referring Party: _____ Employer: _____

Job Title: _____

REASON FOR REFERRAL

To evaluate psychiatric symptoms allegedly related to workplace incident and determine diagnosis, causation, impairment, and treatment recommendations.

SOURCES OF INFORMATION

Sources of Information

- [ ] Patient interview
- [ ] Medical records reviewed (list)
- [ ] Employer reports (if provided)
- [ ] Collateral information (optional)

HISTORY OF PRESENT ILLNESS

Onset:

Course:

Triggers:

Functional Impact:

OCCUPATIONAL HISTORY

Job description:

Length of employment: _____

Prior injuries or claims:

Current work status

◯ working ◯ modified duty ◯ off work

Patient's view on ability to return:

PAST PSYCHIATRIC HISTORY

Previous diagnoses:

Prior treatment (medications, therapy, hospitalizations):

Past trauma or significant stressors:

History of panic attacks or anxiety:

Substance use treatment history (if relevant):

MEDICAL HISTORY

Major medical conditions:

Current medications:

History of head injury or neurologic symptoms:

Sleep disorders:

RELEVANT SUBSTANCE USE HISTORY

Tobacco:

Alcohol:

Cannabis:

Prescription misuse:

Illicit substances:

SOCIAL HISTORY

Living situation:

Family relationships:

Legal issues:

Educational background:

Military history:

Financial stressors:

MENTAL STATUS EXAMINATION

Appearance:

Behavior:

Speech:

Mood:

Affect:

Thought Process:

Thought Content:

Alert and oriented to person, place, time, and situation. Attention and concentration intact. Memory (recent and remote) grossly intact. Fund of knowledge appropriate for age and education.

Insight:

Judgment:

None reported.

PTSD (DSM-5 CRITERIA PROMPTS)

Exposure:

Intrusion symptoms:

Avoidance:

Negative mood/cognition changes:

Arousal/reactivity:

Functional impact:

PANIC DISORDER SCREENING

Timing? (Did the symptoms begin around time of incident?)

Sudden onset?

◯ Y ◯ N

Peak rapidly?

◯ Y ◯ N

Physical symptoms?

◯ Y ◯ N

Afraid of another attack?

◯ Y ◯ N

Avoid associated places/things?

◯ Y ◯ N

DEPRESSION SCREENING

Timing? (Did the symptoms begin around time of incident?)

Low mood, tearfulness?

◯ Y ◯ N

Loss of interest/pleasure?

◯ Y ◯ N

Sleep changes?

◯ Y ◯ N

Appetite/weight changes?

◯ Y ◯ N

Fatigue?

◯ Y ◯ N

Concentration problems?

◯ Y ◯ N

Guilt/worthlessness?

◯ Y ◯ N

Suicidal thoughts?

◯ Y ◯ N

GENERAL ANXIETY SYMPTOMS

Timing? (Did the symptoms begin around time of incident?)

Excessive worry?

◯ Y ◯ N

Restlessness?

◯ Y ◯ N

Muscle tension?

◯ Y ◯ N

Irritability?

◯ Y ◯ N

Worry about work or health?

◯ Y ◯ N

Impact on functioning?

◯ Y ◯ N

RISK ASSESSMENT

Suicidal ideation, plan, intent?

Homicidal ideation?

Violence/aggression history?

Ability to care for self?

Substance-related risks?

DIAGNOSTIC IMPRESSIONS (DSM-5/ICD-10)

Primary, secondary, and rule-out diagnoses:

a

b

c

CAUSATION ANALYSIS

Temporal relationship between symptoms and the workplace event:

Alternative explanations (medical, psychosocial, substance use, prior history):

Degree to which the workplace incident contributed to symptoms:

FUNCTIONAL IMPAIRMENT

Impact on work duties:

Limitations (cognitive, emotional, interpersonal):

ADLs/IADLs:

Whether the impairment is temporary or permanent:

WORK CAPACITY / RESTRICTIONS

Fit for full duty?

◯ Y ◯ N

Fit for modified duty? Y/N (Describe restrictions if any:)

Not fit for duty?

◯ Y ◯ N

Expected duration of restrictions:

TREATMENT RECOMMENDATIONS

Medication:

Psychotherapy:

Work accommodations:

Return-to-work plan:

Further diagnostic testing (if any):

PROGNOSIS

Expected course of recovery:

Factors that may improve or worsen prognosis:

SIGN S. SIGNATURE, MD
License Number: _____ Date: _____ dd / mm / yyyy