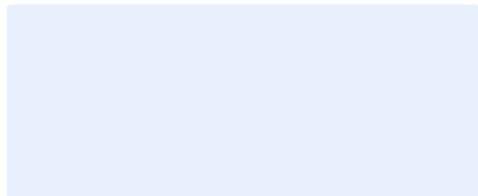
RETAIN WORKS | Retaining Employment and Talent After Injury/Illness Network



30-Day Behavioral Helth Risk Assessment

TO BE COMPLETED BY HEALTHCARE PROVIDER

1. Patient Information

Click or tap to enter a date.	Click or tap to enter a date.
NAME	DATE OF BIRTH

2. Patient is participating in recommended appointments:

- ☐ Yes
- ☐ No
- ☐ N/A

3. Patient's progress

- ☐ As expected/better than expected
- ☐ Slower than expected

4. Factors that may affect return to work (barriers to returning)

____

____

5.

	Work Status	**Date**
☐	Patient is released to return to work without restrictions on:	
☐	Patient may return to work with modified duty or limited hours (see restrictions) on:	
☐	Patient is already working modified duty or limited hours	
☐	Patient not released to return to any work until (estimated date**)**	
☐	Poor prognosis for return to work at any date.	

6. Does this patient's mental health condition require regular appointments?

Appointment Type:	Frequency:	Duration:
☐ Therapy	______ times per week/month	______ weeks/months
☐ Medication Management	______ times per week/month	______ weeks/months
☐	______ times per week/month	______ weeks/months
☐	______ times per week/month	______ weeks/months

7. Patient can:

	Never	**Seldom**	**Occasional**	**Frequent**	**Constant**
		Up to 10% 0-1 hours	11-33% 1-3 hours	34-66% 3-6 hours	67-100% Not restricted
Work in a distracting environment	☐	☐	☐	☐	☐
Attend an in-person meeting	☐	☐	☐	☐	☐
Give a presentation	☐	☐	☐	☐	☐
Direct Interaction with customers/clients (face to face)	☐	☐	☐	☐	☐
Indirect Interaction with customers/clients (phone/chat)	☐	☐	☐	☐	☐
Operate machinery	☐	☐	☐	☐	☐
Other:__________________	☐	☐	☐	☐	☐
Other:__________________	☐	☐	☐	☐	☐

Behavioral Health 30-Day Risk Assessment for (patient name) ____

8. Does the patient need any of the additional accommodations?

☐ Flexible Work Schedule
☐ Opportunity/Time to re-focus on tasks
☐ Extra time to complete assigned tasks
☐ Flexible work location (telework/remote)
☐ Other: ____
☐ Other: ____

Hours per day patient can work unrestricted:	☐ 0	☐ 2	☐ 4	☐ 6	☐ 8	☐ >8

9. New/Additional Breaks Recommended:

Type	Frequency	Duration		
Regular	2 x/day	☐ 5 minutes	☐ 10 minutes	☐ 15 minutes
Seldom	4 x/day	☐ 5 minutes	☐ 10 minutes	☐ 15 minutes
Occasional	Every 50 minutes	☐ 5 minutes	☐ 10 minutes	☐ 15 minutes
Frequent	Every 30 minutes	☐ 5 minutes	☐ 10 minutes	☐ 15 minutes
Other	________________	☐ __ minutes	☐ __ minutes	☐ __ minutes

10. Physical Restrictions (if applicable):

Consider duties like constant walking, climbing a ladder or stairs, reaching, bending, etc.

____
____
____

(if there are restrictions listed above, patient will follow those guidelines)

11. Has a referral been made for a behavioral health workup/assessment?

☐ **Yes** ☐ **No**

If Yes, to which clinic/provider was patient referred? ____

12.

Provider Signature ____

Provider Printed Name ____

Provider Phone Number ____ **Date** __________________________