Behavioral Health Activity Prescription

TO BE COMPLETED BY HEALTHCARE PROVIDER

**can be used with referral if needed*

1. Patient Information

Name ______________________ Date of Birth ______________________

2. Has the patient been diagnosed with a new or exacerbated mental health condition within the last 12 weeks? ☐ Yes ☐ No

3. Is the patient able to do the same type of work as before their new or exacerbated mental health condition? ☐ Yes ☐ No

4. Is the patient able to do modified or a different type of work?
☐ Yes ☐ No ☐ Not employed prior to onset

5. Describe treatment given, ordered, or prescribed by you: (May omit and skip to item 14 if treatment plan is attached and addresses items below)

____

____

6. Is additional treatment needed? ☐ Yes ☐ No

7. Activity Restrictions: ☐ Temporary ☐ Permanent

8. 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

9. 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 Activity Prescription

TO BE COMPLETED BY HEALTHCARE PROVIDER

**can be used with referral if needed*

Behavioral Health Activity Prescription for (patient name) ______________________________

10. 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

11. 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

12. 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)

13. Has a referral been made for a behavioral health workup/assessment? ☐ **Yes** ☐ **No**
If Yes, to which clinic/provider was patient referred? ______________________________

Provider Signature ____

Provider Printed Name ____

Provider Phone Number ______________________________ **Date** ________________