FITNESS FOR DUTY EVALUATION

Examinee Intake Form

EXAMINEE INFORMATION

Full Name:	Gender:	DOB:	Employee ID:	Marital Status:
	☐M ☐F			☐Single ☐Married ☐Divorced ☐Separated

Address:	Phone:	Email:

Emergency Contact:	Phone:	Relationship:

☐ *Examinee declined to provide emergency contact information*

EMPLOYMENT INFORMATION

Employer Name:		Employer Phone:	
Job Title / Position:		Department / Unit:	
Supervisor Name:		Years of Service:	
Employer Address:			

Employee Status: ☐ Active Duty ☐ Admin. Leave ☐ Medical Leave ☐ Suspended ☐ Other

If on leave, date placed:	

REFERRAL INFORMATION

Referred by:	
Reason for Referral:	
In your own words, why were you referred?	

CLINICAL INFORMATION

Primary Care Physician:		Phone / Fax:	

Do you currently see a Mental Health Therapist or Psychiatrist? ☐ Yes ☐ No

Provider Name:		Phone Number:	

FITNESS FOR DUTY EVALUATION – CONSENT & ACKNOWLEDGMENT

I, the undersigned, acknowledge and understand the following regarding this Fitness for Duty (FFD) evaluation:

1. This evaluation is being conducted at the request of my employer. It is not a voluntary or self-referred appointment.

2. This evaluation is for assessment purposes only. **It is not intended to provide treatment, therapy, or ongoing psychiatric care, and no doctor-patient treatment relationship is being established.**

3. A written report summarizing the findings of this evaluation will be provided to the referring party (my employer or their designee). I understand that the contents of this report may be used to make employment-related decisions regarding my fitness to perform my job duties.

4. The information I provide during this evaluation, including responses to interview questions and any completed forms, may not be confidential in the same manner as a traditional therapeutic relationship. The evaluator is obligated to report findings to the referring party.

5. I understand that I have the right to decline to answer any question during the evaluation; however, my refusal to participate or cooperate may be documented in the report and may impact the evaluator's ability to render an opinion.

6. No guarantees have been made regarding the outcome of this evaluation.

By signing below, I confirm that I have read and understand the above terms, and I voluntarily consent to participate in this Fitness for Duty evaluation.

Examinee Signature		*Date*

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES
HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

We want to bring to your attention our Notice of Privacy Practices, which outlines your rights regarding the use and sharing of your personal information. A printed copy of this document is conveniently available at the reception desk. By signing this form, you acknowledge that we have provided you access to the abovementioned information. Furthermore, your signature signifies your acceptance of the terms and conditions outlined therein.

In conducting examinations, diagnoses, and referrals, we must gather what is legally Protected Health Information (PHI) concerning you. This information is imperative in guiding the evaluation process. It is important to note that specific circumstances may necessitate sharing this information with entities responsible for facilitating payment for the services provided, the referring party, or other pertinent business or governmental functions as permitted by law.

It is crucial to underscore that, in the absence of your signature on this consent form, which signifies your agreement to the terms outlined in our Notice of Privacy Practices, we are regrettably unable to proceed with the evaluation. We understand that you might have reservations regarding the use of certain aspects of your information. In such a scenario, you have the right to formally request that we refrain from using your information for specific purposes. This request must be presented in writing, specifying the exact nature of your preferences. While we strive to honor your preferences, we must recognize that adherence to these limitations is not legally mandated. However, should we comply with your stipulations, we assure you that our commitment to adherence will be in accordance with the legal framework.

Please do not hesitate to contact us if you require additional clarification or have any inquiries.

Examinee Name:		**Date of Birth:**	

I acknowledge that MindHope of Oviedo has provided a copy of its Notice of Privacy Practices, which is available for review in the waiting room. I can also request a copy of it. Additionally, it is available on their website at www.mindhopehealth.com.

Effective Date:

Examinee Signature:		***Effective Date:***

THIS SPACE IS INTENTIONALLY BLANK

MEDICATION HISTORY

CURRENT MEDICATIONS

List all prescribed and over-the-counter medications, including vitamins and supplements.

Medication Name	Strength	Frequency	Prescriber

ALLERGIES TO MEDICATIONS

Medication Name	Reaction

MEDICAL PROBLEMS DIAGNOSED BY OTHER DOCTORS

WEAPONS ACCESS & FIREARM INFORMATION

Do your job duties require you to carry a firearm or weapon?	☐ Yes	☐ No
Has your service weapon been surrendered or confiscated?	☐ Yes	☐ No
Do you currently have access to firearms at your residence or any other location?	☐ Yes	☐ No
Do you possess a concealed carry permit?	☐ Yes	☐ No
Have you had any incidents involving the use or discharge of your firearm while on duty?	☐ Yes	☐ No

If yes to any of the above, please provide details:

HISTORY OF MENTAL HEALTH

All information provided in this section is strictly confidential and will become part of your evaluation record.

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you dislike yourself?	☐ Yes	☐ No
If you feel angry, do you tend to keep quiet about it initially but later erupt and lose your temper?	☐ Yes	☐ No

Have you experienced repeated or unexpected attacks during which you suddenly are overcome by fear for no apparent reason?	☐ Yes	☐ No
Do you have upsetting or distressing thoughts, impulses, or images that happen in your mind repeatedly?	☐ Yes	☐ No
Has there ever been a time when you felt so good or so hyper that other people thought you were not your usual self, or you were so hyper that you got into trouble?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No

What stresses you the most?

How long have you been feeling depressed?

SAFETY SCREENING

Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Have you ever thought of hurting someone else?	☐ Yes	☐ No
Any mental health hospitalization or rehabilitation in the last 2 years?	☐ Yes	☐ No

If yes to suicide attempt, how long ago?	
First time? If no, how many times?	
What made you change your mind?	

PRIOR MENTAL HEALTH TREATMENT

Have you ever been to a counselor or therapist?	☐ Yes	☐ No
Have you ever seen a psychiatrist before?	☐ Yes	☐ No

If yes, how long ago?	
Last time you saw your psychiatrist?	

PLEASE CHECK ALL THAT CURRENTLY APPLY TO YOU

☐ Depressed ☐ Sadness ☐ Crying Spells ☐ Loss of Interest ☐ Anxiety ☐ Panic Attacks ☐ Irritability ☐ Rages ☐ Fearfulness
☐ Feelings of Hopelessness ☐ Insomnia ☐ Feelings of Helplessness ☐ Hypersomnia ☐ Fatigue ☐ Forgetfulness ☐ Poor Concentration
☐ Headaches ☐ Weight Loss ☐ No Appetite ☐ Increased Appetite ☐ Thoughts of Suicide

ALCOHOL & SUBSTANCE USE HISTORY

Do you consume alcoholic beverages?	☐ Yes	☐ No	How often? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely ☐ Never
Have you ever used recreational or illicit drugs?		☐ Yes	☐ No
Have you ever been treated at a methadone clinic or received Suboxone treatment in the last two years?		☐ Yes	☐ No

Please note that all information provided is confidential and will be used solely to assist in your evaluation.

I affirm that all the information provided above is accurate to the best of my knowledge.

Examinee Signature		***Date***

MindHope of Oviedo
We Specialize in Psychiatric Evaluations and Treatment of Adults 21 and older

WORKERS COMPENSATION INTAKE FORM

2572 West State Rd. *Suite 3056 *Oviedo, FL 32765*Office 407-706-6580*Fax 407-706-6586

PHQ-9 DEPRESSION ASSESSMENT FOR

Patient Name(print): **Date of Birth:**

Mark with an "X" to indicate your answer	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0☐	1☐	2☐	3☐
2. Feeling down, depressed, or hopeless	0☐	1☐	2☐	3☐
3. Trouble falling or staying asleep, or sleeping too much	0☐	1☐	2☐	3☐
4. Feeling tired or having little energy	0☐	1☐	2☐	3☐
5. Poor appetite or overeating	0☐	1☐	2☐	3☐
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0☐	1☐	2☐	3☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	0☐	1☐	2☐	3☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual	0☐	1☐	2☐	3☐
9. Thoughts that you would be better off dead, or of hurting yourself	0☐	1☐	2☐	3☐
After you have added each individual column then add the total of the three columns and write that total number in the TOTAL SCORE SECTION				

		+	

= TOTAL SCORE:

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ **Not difficult at all** ☐ **Somewhat difficult** ☐ **Very difficult** ☐ **Extremely difficult**

Patient Signature: **Date:**

Client's Right: Rules Under Chapter 440, Florida Statutes. "In Florida, an injured worker has the right to select a pharmacy or pharmacist. Florida Law prohibits interference with the right the patient has to choose a pharmacy at any time a patient becomes dissatisfied with their pharmacy or pharmacist's services, they can seek another pharmacy to fill their prescription. The Insurer, Attorney, Adjuster or Case Manager, Physician, or Nurse cannot interfere with their rights to choose which pharmacy they prefer.

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