# RWORK2CONFIRMATION OF DISABILITY & SERVICE PLANNING –

# Information Request

**Patient Name**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ Date of Birth:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1. Current Risks:** *(please select one rating for each type of risk. Key: 0=none; 1=mild, ideation only; 2=moderate, ideation with either plan or history of attempts; 3=severe, ideations AND plan, with intent or means; NA = not Assessed.)*

**No Impact ………………………………………Severe……….Not Assessed**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Client’s risk to self | 0 | 1 | 2 | 3 | Not Assessed |
| Client’s risk to others | 0 | 1 | 2 | 3 | Not Assessed |

**2. Current Impairments that could have impact on the client’s ability to work or attend school:** Key: 0=none, 1=mild or mildly incapacitating, 2=moderate or moderately incapacitating, 3=severe or severely incapacitating, na=not assessed for this impairment

**No impact ..…………………………….. Severe…….** **Not Assessed**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Mood Disturbances (depression or mania) | 0 | 1 | 2 | 3 | Not Assessed |
| Anxiety | 0 | 1 | 2 | 3 | Not Assessed |
| Psychosis/Hallucinations/Delusions | 0 | 1 | 2 | 3 | Not Assessed |
| Thinking/Cognition/Memory/Concentration Problems | 0 | 1 | 2 | 3 | Not Assessed |
| Impulsive/Reckless/Aggressive Behavior | 0 | 1 | 2 | 3 | Not Assessed |
| Lifting Capacity: **Max. kg**.:\_\_\_\_\_\_\_  Carrying Capacity: **Max. kg**.:\_\_\_\_\_\_ | 0 | 1 | 2 | 3 | Not Assessed |
| Prolonged Sitting | 0 | 1 | 2 | 3 | Not Assessed |
| Prolonged Standing | 0 | 1 | 2 | 3 | Not Assessed |
| Prolonged Walking | 0 | 1 | 2 | 3 | Not Assessed |
| Hearing | 0 | 1 | 2 | 3 | Not Assessed |
| Vision | 0 | 1 | 2 | 3 | Not Assessed |
| Substance Abuse/Dependence | 0 | 1 | 2 | 3 | Not Assessed |
| Legal Problems | 0 | 1 | 2 | 3 | Not Assessed |

**3. Please identify diagnosis/provisional diagnosis you have available on this client:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4. Are you in support of the client participating in vocational rehabilitation services at this time? \_\_\_ Yes \_\_\_No**

**\*Would he/she be ready to work a minimum of 15 hours/week? \_\_\_Yes \_\_\_No**

**- If yes, would you anticipate that he/she be able to maintain work for up to 6 months? \_\_\_Yes \_\_\_No**

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**5. Is the client currently on Medication? \_\_\_Yes \_\_\_No *If yes, please comment below:***

***5a. Usually adherent? \_\_\_Yes \_\_\_No \_\_\_Not Assessed***

***6.* Potential Safety concerns for this client include:**

**\_\_Heights \_\_Driving \_\_Operating Equipment \_\_Heat**

**\_\_Other (please identify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_No concerns**

**7. Please comment on any other issues that you believe may be important in return to work/school planning:**

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***Completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***\_\_\_

***Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***