Attending Physician Statement
Behavioral Health (page 1)

Phone: (866) 206-6769| Web: www.mySedgwick.com/Starbucks| Fax: (866) 315-0607
Email: Starbucksmail@sedgwick.com|Sedgwick, P. O. Box 14424, Lexington, KY 40512-4424

Patient Name: Ben Cave
Claim Number: 4A2403KWDV8-0001
Due Date: 04/08/2024

Once this form is completed, please return by email to **Starbucksmail@sedgwick.com** or fax to **(866) 315-0607**.

Section 1: Required information to support FMLA/State Leave

1. Will the patient be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? Yes ☑ No ☐
   If yes, estimate the beginning and ending dates for the period of incapacity: 02/26/24 through 03/31/2024.
2. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? Yes ☑ No ☐
   If yes, dates of admission: 02/26/24 through 03/11/2024.
3. Date(s) you treated the patient for condition: 02/26/24 To 03/11/24,
4. When is the patient's next office visit? ___/___/___ none (Discharged to outpatient)
5. Was medication, other than over-the-counter medication prescribed? Yes ☑ No ☐
6. Is the medical condition pregnancy? Yes ☐ No ☑ If yes, expected delivery date: ___/___/___
7. Is the patient unable to perform any of his/her job functions due to their condition: Yes ☐ No ☑
   If yes, identify the job functions the employee is unable to perform (use the list of the employee's essential functions or job description, if included, or answer this question based upon the patient's own description of his/her job functions)

   _____

   _____
8. Describe other relevant medical facts, if any, related to the condition for which the patient seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment). DO NOT INCLUDE DIAGNOSIS IF PATIENT IS IN CA OR CT:
   ADMITTED TO INPATIENT PSYCH UNIT FROM 02/26/24 & TO ATTEND INTENSIVE OUTPATIENT PROGRAM THP.

Section 2: Required information to support Disability Benefits

The patient's current disability plan requires that medical information indicate an inability to perform the essential duties of his/her own job.

Patient's occupation:

_____

Have you recommended to your patient to stay home from work? ☑ Yes ☐ No If yes, effective what date? 02/26/24.

Please provide your rationale for recommending the patient stay home from work
ADMITTED TO INPATIENT UNIT ON 02/26/24
DISCHARGED ON 03/11/24. ATTENDING
INTENSIVE OUTPATIENT PROGRAM TILL 03/29/2
TO RETURN TO WORK ON
MONDAY 04/01/2024.

Attending Physician Statement
Behavioral Health (page 2)

Patient Name: Ben Cave
Claim Number: 4A2403KWDV8-0001

Can your patient return to work with accommodations? ☐ Yes ☑ No If Yes, effective what date? ___/___/___

Please describe accommodations: _____

Your patient will be released to work full duty on: 04/21/2024.

Please support your opinion with the following information:

(Please attach all office notes, History & Physical, results of x-rays, laboratory tests, MRI Reports, etc, if relevant)

DIAGNOSIS

Primary: ICD Code: F 31.6 Description: BIPOLAR DISORDER MIXED EPISODE

Secondary: ICD Code: _____ Description: _____

COGNITIVE FUNCTIONING EVALUATION

Applied focus and concentration in session for periods of:

☐ 30 to 50 minutes ☑ 15 to 30 minutes ☐ 5 to 10 minutes ☐ less than 5 minutes

Expressed his/her current circumstances and responded to direct questions appropriately: ☑ Yes ☐ No

If No, was redirection needed? ☐ Yes ☐ No Please describe: _____

Reasoning and/or Judgment: ☑ Within normal limits ☐ Impaired If impaired, please describe: _____

Delusional ideations evident: ☐ Yes ☑ No If yes, please describe: _____

Hallucinations reported: ☐ Yes ☑ No If yes, please describe: _____

Memory functions: Four (4) unrelated words after five (5) minutes: ___ Other testing results: NORMAL LIMITS

Able to perform five operations of serial 7's or 3's: ☑ Yes ☐ No

Exam findings: INTACT.

Able to follow direction and verbalize directions given during exam? ☑ Yes ☐ No

If no, please describe: _____

Able to read a narrative paragraph from a magazine or newspaper and report the main concept/idea of the passage:

☑ Yes ☐ No

EMOTIONAL FUNCTION AND BEHVAIORAL OBSERVATIONS

Date of last exam: 3/11/24 Behavior(s) and emotional state observed during exam: MILDLY ANXIOUS BUT NOT SUICIDAL AND NOT PSYCHOTIC

Able to spontaneously compose her/himself: ☑ Yes ☐ No If no, please explain: _____

Psychomotor activity and ability to apply effort: ☑ unremarkable ☐ Impaired If impaired, describe: ___

Presented with appropriate dress and hygiene in session: ☑ Yes ☐ No If no, please describe: _____

Impulse control: ☐ Physical abusive behavior ☐ Verbal abusive behavior ☐ Substance abuse/addiction ☐ alcohol abuse/addiction ☐ Manic Behavior

Speech: ☐ Slurred ☐ Pressured ☐ Stammering ☐ Loud ☑ Soft ☐ Over Productive ☐ Under Productive

☐ Other (please describe) _____

Attending Physician Statement
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atient Name: Ben Cave
laim Number: 4A2403KWDV8-0001

sk to self/others:

icidal Ideations ☐ Yes ☑ No Plan reported: ☐ Yes ☐ No If yes, please explain: _____

micidal Ideations ☐ Yes ☑ No Plan reported: ☐ Yes ☐ No If yes, please explain: _____

le to report reasons for not harming self/others: ☑ Yes ☐ No If no, please explain: _____

ntracted for safety: ☑ Yes ☐ No If no, please explain: _____

TIENT SELF REPORT OF ACTIVITIES OF DAILY LIVING

the patient currently performing any of the following?:

] Volunteer work ☐ Works at a lesser demanding job ☑ Attending school ☐ No work activities in any capacity

] Self-employment

as the patient conceptualized the following areas as barriers in returning to work:

] Increase in work demands ☐ Conflicts with supervisor ☐ Anticipation of relapse

] Recent unfavorable work evaluation ☐ Dissatisfaction with the job ☐ Other (please specify) N/A.

as the patient expressed or are you aware that she/he is experiencing any psychosocial stressors? ☑ Yes ☐ No If yes, please escribe: FAMILY CONFLICTS & SCHOOL STRESS

ignificant weight changes: ☐ Yes ☑ No Current weight: _____

revious weight: 78.2 KG Date of previous weight: 03/12/2024.

ignificant appetite changes: ☐ Yes ☑ No If yes, please describe diet: _____

Significant sleep disturbance: ☐ wakes more than twice per night ☐ sleeps less 4 hours or less ☐ sleeps 12 hours or more

Are any of the above weight, appetite, or sleep disturbances related to medication side effects? ☐ Yes ☐ No If yes, please describe: _____

Panic attacks: ☐ Yes ☑ No Please specify below:

- Frequency of panic attacks: _____
- Duration of panic attacks: _____
- Symptoms experienced during panic attacks: _____

Socialization problems: ☑ Yes ☐ No If yes, please describe: SOCIAL ISOLATION.

Is patient able to: Clean/maintain residence: ☑ Yes ☐ No

Perform routine shopping: ☑ Yes ☐ No Pay bills: ☐ Yes ☐ No

Operate motor vehicle: ☐ Yes ☐ No If no to any of these, please explain: _____

TREATMENT

Date initiated care: 02/26/2024.

Inpatient care: Date(s) of hospitalization: 02/26/2024 TO 03/11/2024.

Partial hospitalization programs: _____ Date(s) of care: _____

Intensive outpatient (IOP): Start date: 03/17/2024 End date: 03/21/2024.

Days per weeks: _____ Hours per day: _____

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Patient **Name: Ben Cave**
Claim **Number: 4A2403KWDV8-0001**

Outpatient psychotherapy: Frequency: _____ Date of next visit: unknown

Medication management: Frequency: 1 month Date of next visit: will let you.

Current medications/changes in medication-list all medications and identify dates of new medications or dose adjustments: (attach list if necessary)

	Medication	Dose	Frequency	Duration	New Med	Adjusted Med	Date Adjusted
(1)	ZYPREXA	15 mg	at Bedtime		Yes ☑ No ☐	Yes ☑ No ☐	03/11/2024.
(2)	ZOLOFT	50 mg	daily		Yes ☑ No ☐	Yes ☑ No ☐	03/11/2024.
					Yes ☐ No ☐	Yes ☐ No ☐	__/__/__
					Yes ☐ No ☐	Yes ☐ No ☐	__/__/__

Medication side effects: ☐ Yes ☑ No If yes, please describe: _____

Please attach all office notes, History & Physical, etc., if relevant.

Telephone Number: 215-643-7800 ext 5428
Fax Number: 215-542-4801
Date Completed: 03/29/2024

Physician Printed Name: Olumide Oluwabusi, MD
Physician Specialty: PSYCHIATRY
Physician Signature: [signature]

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.