### Instructions
- A mental health professional may use this form to submit mental health notes.
- BWC/managed care organizations (MCOs) will use this mental health notes summary as part of the management of the medical part of the claim.
- Please print or type this report, and fax or mail it to the appropriate MCO.
- To determine the appropriate MCO, ask the injured worker or employer, visit www.bwc.ohio.gov or call 1-800-644-6292, and listen to the options.
- If the injured worker is employed by a self-insuring employer, complete this form, and mail or fax it to the self-insuring employer.
- You can obtain additional copies of this form on www.bwc.ohio.gov or by calling 1-800-644-6292 and listening to the options.

### Mental Health Notes Summary

<table>
<thead>
<tr>
<th>Patient name</th>
<th>Claim number</th>
</tr>
</thead>
</table>

**BWC allowed condition(s) (DSM, IV, Axis) being treated**

<table>
<thead>
<tr>
<th>Treatment frequency and duration</th>
<th>Modalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>From: ________________________</td>
<td>To: ________________________</td>
</tr>
<tr>
<td>Duration/Length</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

#### Treatment
- Supportive
- Cognitive behavioral
- Psychodynamic
- Medication
- Other ___________________________________________________________________________

#### Medication prescription and monitoring:

### Symptoms during service:
- Anxiety
- Depression
- Mania behavioral
- Disturbances
- Psychotic
- Organic
- Substance use
- Somatic
- Dissociation
- Sexual
- Sleep
- Impulse control
- Retardation
- Learning problems
- Other ___________________________________________________________________________

### Prognosis:
- Good
- Fair
- Poor

### Progress:
- No change
- Worsened
- Improved
- Approaching complete
- Complete
- N/A-initial

**Plan/Goals** (indicate barriers, if applicable): Attach additional sheet if necessary.

### Functional status

Please provide additional summary information regarding functional status and/or the ability to remain/return to work or any other information. Attach additional sheet if necessary.

<table>
<thead>
<tr>
<th>Mental health provider name (please print or type)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>