EHR SUPPLEMENT FOR MENTAL HEALTH ABSENCES

HEALTH SERVICES

Section 1: Employee Completes Entire Section (Please Print)

ALL INFORMATION IS CONFIDENTIAL
Fax Completed Form To
918-977-8840

Employee Name (Last, First, MI)	Employee ID Number	Employee Phone Number
Employee Address, City, State, Zip		

First Day of Injury/Illness	First Day Missed Work	Is this a Work Place Injury/Illness?	Supervisor Notified?	Employee Home Email Address
		☐ Yes ☐ No	☐ Yes ☐ No	

Work Location	Position	D.O.B. (mm/dd/yyyy)

Supervisor Information: Name	Phone	E-mail

I hereby authorize the undersigned Licensed Health Care Professional **(LHCP)** to release information to or to discuss with a Phillips 66 LHCP, any information regarding this injury or illness (continued on next page).

Employee Signature	Date Signed:
X	

ATTENTION LHCP: Phillips 66 promotes a TRANSITIONAL DUTY PROGRAM.
Please complete ALL of the information below concerning the employee's work status.

Section 2: LHCP completes: (Please Print)

Date of Visit:	Medical condition, symptoms &other medical facts for which a patient is being treated	DSM V Code(s)

Complications Impeding Recovery?	Describe Complications:
☐ Yes ☐ No	

Date of Next Visit/Appointment	Anticipated Outcome and Duration (Check all that apply):
	☐ <1 mos ☐ 1-3 mos ☐ 3-6 mos ☐ >6 mos ☐ Return to Work, Full Duty ☐ Return to Work with Modifications ☐ Not Expected to Return to Work ☐ Unknown

Is employee undergoing any medication management? ☐ Yes ☐ No **If "Yes", Please Provide Following Information:**

Medication Name	Dosage	Date Prescribed	Prescriber Name	Prescriber Role
				☐ PCM/PCP ☐ Psychiatrist ☐ Other_____
				☐ PCM/PCP ☐ Psychiatrist ☐ Other_____
				☐ PCM/PCP ☐ Psychiatrist ☐ Other_____
				☐ PCM/PCP ☐ Psychiatrist ☐ Other_____

Is employee undergoing any counseling? ☐ Yes ☐ No **If "Yes", Please Provide Following Information:**

Counselor Name	Frequency of Visits	Date Commenced

Additional Treatment Recommendations or Comments:

CHECK OR COMMENT BELOW ON EMPLOYEE'S ACTIVITY CLEARANCE, MODIFICATIONS or LIMITATIONS.
Employees and Providers are reminded that Activity Modifications or Limitations apply at Work and Home.

Please indicate the employee's current readiness to return to full activities/work on a scale of 1-5 (1=Cannot Return, 5=Ready to Return)

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Please indicate the psychiatric/psychological symptoms currently preventing the employee from performing primary job activities.
(Severity Range of 1=Mild, 5=Severe)

Symptom	Duration of Symptoms (wks/mos/yrs)	Level of Impairment				
		☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
		☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
		☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

☐ **No Activities or Work of Any Type (please explain why):**

☐ **Regular Activities** – Release with NO Activity Modifications or Limitations on (date)_____

☐ **Modified Activities** –

Start Date of Modified Activities	End Date of Modified Activities

Duration of Modifications: ☐ Temporary ☐ Permanent ☐ Unknown

May Perform Following:
☐ Work Full Shifts ☐ Work Reduced Shifts at _____ hrs/day ☐ Work Reduced Shifts as Tolerated
☐ Drive Personal Vehicle ☐ Operate Heavy Machinery ☐ Work in Safety Sensitive Position

LHCP Information – MUST BE COMPLETED

LHCP Signature	Address:
LHCP Name – Print	

Date Signed:	Phone Number:	Fax Number:

Phillips 66 Workplace Employee Assistance Program Coordinators

Address	Phone Number	Cell Number	Fax Number
Lisa Countryman Workplace EAP Coordinator 411 S. Keeler AB-232D Bartlesville, OK 74003	918-977-5742	918-977-0240	918-977-8840
David Stawecki Workplace EAP Coordinator 1075 W. Sam Houston Parkway N. Suite 200 Houston, TX 77043	832-765-2400	337-842-8512	918-977-8840
Lisa Countryman Workplace EAP Coordinator New Jersey Refinery	918-977-5742	918-977-0240	918-977-8840
Stephen Degelsmith Workplace EAP Coordinator California Refineries	310-952-6316		918-977-8840

For general questions or to determine the coordinator for your region contact:

HR Connections
855-480-6634
Monday – Friday
8 a.m. to 6 p.m. (CST)

Additional Consent Information

I understand that this authorization is voluntary and that a Phillips 66 Licensed Health Care Provider includes a physician, nurse, nurse practitioner, case manager, physician assistant, or employee assistance program (EAP) counselor. I also understand failure to provide authorization could affect my eligibility for Phillips 66 Short Term Disability benefits. This authorization will remain in effect for the lesser of 30 calendar days from the licensed health care provider's signature date or until I return to work on the basis of full duty OR one week from the date of my next documented appointment but not longer than 60 days from the date of the licensed health care provider's signature.

I have read and understand the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any effect on any actions the entity took before it received the notification.
- I may see a copy of the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).

The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity. I have the right to seek assurances from the above-named persons to organizations authorized to receive the information that they will not re-disclose the information to any other party without my further authorization.

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.