Medical Clearance Form

To Whom It May Concern,

Please fill in this form to indicate the amount of work that your client/patient is able to undertake.

WORK OPPORTUNITIES

Specialising in Mental Health

Client Name

Mental Health Diagnosis

- ☐ Mild Depression
- ☐ Moderate Depression
- ☐ Severe Depression (Clinical)
- ☐ Mild Anxiety
- ☐ Moderate Anxiety
- ☐ Severe Anxiety
- ☐ Social Phobia
- ☐ Post Traumatic Symptoms
- ☐ Post Traumatic Disorder
- ☐ Personality Disorder
- ☐ Asperger's
- ☐ Autism
- ☐ Mood Disorder
- ☐ Post Natal Depression
- ☐ Psychotic Disorder
- ☐ Schizophrenia
- ☐ Bipolar 1
- ☐ Bipolar 2
- ☐ ADHD/ADHA
- ☐ Other (please specify)

Recommended Weekly Hours

Comments

Does your client already have a job? ☐ Yes ☐ No

What type of support would you recommend they receive in employment?

Health Professional Name

Signature

Client Signature

Date

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