|  |  |
| --- | --- |
|  | OMB Control No. 0420-xxxx  Expiration Date xx/xx/xxxx Peace Corps |

**MENTAL HEALTH CURRENT EVALUATION FORM**

**(CONFIDENTIAL)**

The individual listed above has applied to serve as a Peace Corps Volunteer and has reported a history of a mental health condition, mental health counseling, or use of medication for mental health. The mental health provider who has oversight and management of the applicant’s treatment, or has access to the applicant’s mental health records, should complete this mental health current evaluation form. If you do not have access to the appropriate records, please indicate this on the form.

**Note to the Provider**: Please be candid when answering the questions below. During Peace Corps service, a Volunteer may be placed in a community that is very isolated and remote and has a history of violence, high crime, extreme poverty, or inequitable treatment. There may be limited access to Western-trained mental health professionals and little support for existing or new mental health symptoms. **Please answer all questions or the form will be considered incomplete and returned to the applicant.**

**Applicant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mental Health Provider’s Name:** **Date:**

**Professional Degree:**  **License No.:** **State:**

**Address:**  **Tel:** \_\_\_\_

**Dates of Evaluation Sessions:** *(Note to the Provider: Please complete the dates of evaluation sessions, up to three separate visits, as you feel is necessary to evaluate the current mental health status. Three visits are not required if one or two sessions are sufficient time to complete an assessment)*

a.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prior to this evaluation, have you treated this applicant for a mental health condition?

Yes \_\_\_\_\_ No \_\_\_\_

Have you received mental health reports for this applicant? Yes \_\_\_\_\_ No \_\_\_\_

(Where applicable, please have the applicant include information about psychiatric hospitalizations.)

**MENTAL HEALTH HISTORY**

1. **DIAGNOSES HISTORY: (DSM IV Codes)**

|  |  |
| --- | --- |
| **Diagnoses** | **Date Given** |
| Axis I: |  |
| Axis II: |  |
| Axis III: |  |
| Axis IV: |  |
| Axis V: |  |

1. **PRESENTING SYMPTOMS: *Please be as specific and comprehensive as possible.***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Symptom | Onset | Severity | Duration | Date remitted |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**CURRENT MENTAL HEALTH EVALUATION**

**A. Clinical Assessment, with focus on:**

1. Ego strength, emotional stability, and flexibility:

2.) Risk of symptom recurrence in a stressful overseas environment (*characterized by isolation, lack of structure, and limited social supports*):

3.) Coping strategies:

**B. Assessment of Current Functioning:**

1.) Evaluation of overall functioning:

2.) Interpersonal relationships:

3.) Work relationships:

**C. Current Assessment: DSM IV:**

|  |  |
| --- | --- |
| **Diagnoses** | **Date Given** |
| Axis I: |  |
| Axis II: |  |
| Axis III: |  |
| Axis IV: |  |
| Axis V: |  |

**D. PSYCHOTROPIC MEDICATIONS (*Current and Previous)*:**

***Please have the prescribing mental health professional complete this portion.***

Medication and Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Response to Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recommended Monitoring Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication and Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Response to Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recommended Monitoring Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication and Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Response to Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recommended Monitoring Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature and title if different from the person completing the rest of this form:*

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

*Name and title Date*

**E. Current Psychological Tests Administered *(Please attach any pertinent reports or summaries, if any)*:**

a.

b.

**F. Clinical Observations:**

**G. Recommendations and Follow up:** What specific recommendations for mental health support do you have regarding the management of this condition over the next three years? **All recommendations will help determine the best placement for the Peace Corps Volunteer.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any concerns that would prevent this applicant from completing 27 months of service without undue disruption due to a mental health condition? NOTE: Peace Corps service may be in areas that are isolated or have limited access to Western-trained providers and health care systems. Please check one box below.

I have no concerns. This applicant, with regard to mental health conditions, is healthy enough to complete 27 months of uninterrupted Peace Corps service provided these recommendations can be accommodated.

I am unsure that this applicant can, due to a mental health condition, complete 27 months of uninterrupted Peace Corps service. I recommend a period of stabilization for this condition and an updated assessment at a future date. Please describe and include length of time for stabilization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I do not believe that this applicant can, due to a mental health condition, complete 27 months of Peace Corps service without disruption.

**I certify this information is, in my opinion, an accurate representation of the baseline status of this mental health condition for the applicant listed above.**

Mental Health Provider Signature/Title

Mental Health Provider Name (Print)

Date