Applicant Name _____
(Last, First, Middle Initial)

Date of Birth_____/_____/_____ Medical Case Number:_____
(Mo/Day/Year)

Eating Disorder Treatment Summary Form
OMB No.: 0420-0550
Expiration Date: 1/31/2014

EATING DISORDER TREATMENT SUMMARY FORM
(CONFIDENTIAL)

The individual below has applied to serve as a Peace Corps Volunteer and has reported a past or active eating disorder. This form must be completed by the health care provider who has oversight and management of the condition.

Note to the Mental Health Professional: When answering the questions below, please consider that there are many assignments where the Volunteer may be isolated and exposed to violence and crime, extreme poverty, or inequitable treatment. There may be limited access to Western-trained mental health professionals and little support for existing or new eating disorder symptoms. **Please answer all questions or the form will be considered incomplete and returned to the applicant.**

Privacy Act Notice

This information is collected under the authority of the Peace Corps Act, 22 U.S.C. 2501 et seq. It will be used primarily for the purpose of determining your eligibility for Peace Corps service and, if you are invited to serve as a Peace Corps Volunteer, for the purpose of providing you with medical care during your Peace Corps service. Your disclosure of this information is voluntary; however, your failure to provide this information will result in the rejection of your application to become a Peace Corps Volunteer.

This information may be used for the purposes described in the Privacy Act, 5 USC 552a, including the routine uses listed in the Peace Corps' System of Records. Among other uses, this information may be used by those Peace Corps staff members who have a need for such information in the performance of their duties. It may also be disclosed to the Office of Workers' Compensation Programs in the Department of Labor in connection with claims under the Federal Employees' Compensation Act and, when necessary, to a physician, psychiatrist, clinical psychologist or other medical personnel treating you or involved in your treatment or care. A full list of routine uses for this information can be found on the Peace Corps website at http://multimedia.peacecorps.gov/multimedia/pdf/policies/systemofrecords.pdf.

Burden Statement:

Public reporting burden for this collection of information is estimated to average 105 minutes per applicant and 60 minutes per mental health professional per response. This estimate includes the time for reviewing instructions and completing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: FOIA Officer, Peace Corps, 1111 20th Street, NW, Washington, DC, 20526 ATTN: PRA (0420 - 0550). Do not return the completed form to this address.

Medical Case Number: _____

Mental Health Specialist:_____Date:_____

Professional degree:_____ License No.:_____ State: _____

Address:_____Phone: _____

1. Dates and Frequency of Therapy Sessions:

Date of First Session: _____ Frequency of Sessions: _____

Date of Last Session: _____ Was this a Final Session? ☐ Y ☐ N

If yes, was termination satisfactory and mutual? _____

2. Diagnoses [DSM IV Codes] (List all diagnoses)

If giving a diagnosis of Eating Disorder not otherwise specified, please list criteria that are NOT evidenced to record a diagnosis of Anorexia or Bulimia

Working Diagnoses	Date Given	Date Resolved	Current Diagnosis
Axis I:	(MM/YY)_____	(MM/YY)_____ ☐ ongoing	Axis I:
Axis II:	(MM/YY)_____	(MM/YY)_____ ☐ ongoing	Axis II:
Axis III:	(MM/YY)_____	(MM/YY)_____ ☐ ongoing	Axis III:
Axis IV:	(MM/YY)_____	(MM/YY)_____ ☐ ongoing	Axis IV:
Axis V:	(MM/YY)_____	(MM/YY)_____ ☐ ongoing	Axis V:

3. Presenting Problem and Precipitating Factors:

4. Symptoms: Please be as specific and comprehensive as possible. Also, please include weight control behavior.

Symptom	Onset	Severity	Duration	Date remitted

Residual symptoms, if present: _____

5. Documentation of Weight Over the Past Three Years: _____

_____

_____

_____

Medical Case Number:

6. Course of Treatment: _____

_____

_____

_____

_____

7. Psychotropic Medications, Current and Present:

Medication and Dosage:_____

Start Date:_____ End Date:_____

Response to Medication:_____

Medication and Dosage:_____

Start Date:_____ End Date:_____

Response to Medication:_____

Please continue on reverse side of this page, if necessary

8. Mental Health History

Previous Counseling ☐ N/A If yes, describe:	Dates if known	DSM Diagnosis if known
Psychiatric Hospitalizations ☐ N/A If yes, describe:	Dates if known	Location:

Suicide Attempt(s) dates)	**Suicidal Gestures (dates)**	**Suicide Ideation (dates)**
☐ N/A If yes, describe: Risk of recurrence? ☐ None or unlikely ☐ Possible or likely (describe): ☐ I am unable to assess this	☐ N/A If yes, describe: Risk of recurrence? ☐ None or unlikely ☐ Possible or likely (describe): ☐ I am unable to assess this	☐ N/A If yes, describe: Risk of recurrence? ☐ None or unlikely ☐ Possible or likely (describe): ☐ I am unable to assess this

Medical Case Number:

9. Level of Functioning

History	Interpersonal (describe):	Work/Educational (describe):
Current	Interpersonal (describe):	Work/Educational (describe):

10. Prognosis: _____

_____

11. Risk of exacerbation or recurrence *(please consider issues of isolation, different environments, lack of structure and social support, and limited control over food)* _____

_____

12. What specific recommendations for eating disorder support do you have regarding the management of this condition over the next three years? All recommendations will help the Peace Corps determine the appropriate Volunteer placement _____

_____

Attach:

- Required: Current fasting comprehensive metabolic panel and thyroid function tests (TFTs)
- B12, folate and iron, if applicable

Do you have any concerns that would prevent this applicant from completing 27 months of Peace Corps service without disruption due to an eating disorder? 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 eating disorders, is healthy enough to complete 27 months of uninterrupted Peace Corps service provided the above recommendations can be accommodated.

☐ I am unsure that the applicant can complete 27 months of uninterrupted Peace Corps service due to an eating disorder. I recommend a period of stabilization for this condition and an updated assessment at a later date. (Describe and include length of time for stabilization.) _____

_____

_____

☐ I do not believe that this applicant is or will be able to complete 27 months of Peace Corps service without disruption due to an eating disorder.

I certify this information is, in my opinion, an accurate representation of the baseline status of the applicant's eating disorder.

Mental Health Professional Signature/Title _____

Mental Health Professional Name (Print) _____

Date _____