Applicant Name _____
(Last, First, Middle Initial)

Date of Birth_____/_____ /_____

TRANSFER OF CARE FORM – REQUEST FOR INFORMATION

Note to the health-care provider:

- Peace Corps physicians will be assuming responsibility for the health care of your patient, <<NAME OF PERSON>>, for the period <<INSERT PERIOD OF SERVICE>> for Peace Corps service in <<COUNTRY INVITED>>.
- Peace Corps Volunteers typically live in remote settings that are hours away from rudimentary health-care services; in the closest major cities, health resources are usually limited.
- The health-care professionals in the Peace Corps Office of Health Services need a complete and clear understanding of your patient's <<BODY SYSTEM>> conditions.
  - o <<LIST CONDITIONS FOR BODY SYSTEM>>
    - ▪ ONLY SELECT CONDITIONS
- **Please provide a signed written narrative or copies of documents from the medical record detailing the information requested below.**

Please provide medical management information for the condition(s) listed above:

1. How and when was the diagnosis established? Please include copies of the results of the original objective testing or provide a detailed written narrative, as well as the ICD-10 code(s).
2. What is the current treatment, if any? Please indicate if there were any previous treatments that failed or were not tolerated. What are the current signs and/or symptoms, if any?
3. What physical limitations, if any, exist (i.e. activity, altitude, other environmental restrictions)?
4. What is the likelihood of significant progression of this condition over the next three years?
5. What clinical follow-up is indicated for this condition (i.e., specific diagnostic studies, consultant follow-up) over the next three years? If follow-up diagnostic studies are indicated, please include copies of the most recent of these studies to serve as a baseline.

PRIVACY ACT NOTICE

BURDEN STATEMENT