Substance-Related and Addictive Disorders Current Evaluation Form
OMB No.: 0420-0550
Expiration Date: 00/00/0000

Applicant Name _____
(Last, First, Middle Initial)

Date of Birth_____/_____/_____
(Mo/Day/Year)

Substance-Related and Addictive Disorders Current Evaluation Form (Confidential)

The individual listed above has applied to serve as a Peace Corps Volunteer and has reported a history of a substance-related and/or an addictive disorder. 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 form. If you do not have access to appropriate records, please indicate this on the form.

Note to the Mental Health 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, with the potential for a history of high crime, history of violence, current extreme poverty, and/or inequitable treatment of members of the population. . There may also be limited access to Alcohol Anonymous (AA), Narcotics Anonymous (NA), Western-trained mental health professionals and little support for existing or new mental health symptoms. Please take these factors into consideration when answering the questions below. This form will also be considered "incomplete" and returned to the applicant if all questions are not answered.

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 service 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 or failure to disclose relevant information may 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 U.S.C. 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, licensed clinical social worker 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 four hours and 25 minutes per applicant and three hours per substance abuse 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 complete from to this address.

Mental Health Provider's Name and Degree (Print): _____

Date: _____ License No.: _____ State: _____

Address: _____ Phone: _____

Certified Substance-Related and Addictive Disorder Counselor? ☐ Yes ☐ No

Dates of Evaluation Sessions

Note to the provider: Please complete as many evaluation sessions (one, two, or three visits) as you feel is necessary to evaluate the current identified concern(s). 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 condition? ☐ Yes ☐ No

Have you received reports of prior treatment for this applicant? ☐ Yes ☐ No
If marked "No" or documentation is insufficient, then please be sure to inquire fully about the applicant's health and treatment history.

Please provide the following information based on your treatment and/or clinical assessment of this applicant. Please be as detailed as possible. ***Where applicable, please have the applicant include information about arrests or other disciplinary actions due to alcohol or drug use.***

A. Past & Current Clinical Disorders (Formerly Axes I, II, and III in DSM-IV-TR)

Please indicate date given and date remitted, if applicable. Please also indicate if no current diagnosis is present or if diagnosis is ongoing.

Mental Disorders:

Diagnosis	Date Given	Date Remitted	Ongoing (Yes/No)
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

General Medical Disorders:

Diagnosis	Date Given	Date Remitted	Ongoing (Yes/No)
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

B. Psychotropic Medications (Current & Previous)

**** If possible, please have the prescribing clinician complete this section. ****

Medication and Dosage	Start Date	End Date	Response to Medication	Recommended Monitoring Plan

Signature: _____ Date: _____

Name & Title (Print): _____

C. History of Symptoms/Behaviors of Concern

Please be as specific and comprehensive as possible. If more space is needed, please use blank page or back of this form.

Substance(s) of choice:

_____

_____

"Yes" Requires Comment(s)		Comment(s)
At what age did the applicant begin use?		_____ (in years)
What was the frequency and extent of use? **Report frequency and extent.*		_____ (times per day/week) _____ (amount/quantity) _____ (for how long)
History of blackouts or loss of consciousness/memory? **Include dates and circumstances.*	☐ Yes ☐ No	
History of negative psychosocial repercussions (primary support group, legal, work, economic/housing) related to alcohol/drug use? **Provide dates and circumstances.*	☐ Yes ☐ No	
History of physical problems related to alcohol/drug use? **Include dates, diagnosis, and details of treatment.*	☐ Yes ☐ No	
History of use of AA/NA meetings or longer-term supports to maintain sobriety/abstinence? **If yes, what is the longest length of time the applicant has gone without a meeting and what was the result?*	☐ Yes ☐ No	

D. Clinical Assessment of Current Functioning and Substance/Alcohol Use

Current Assessment of Use	Comments
Is the applicant currently sober/abstinent? **If yes, include length of sobriety/abstinence.*	☐ Yes ☐ No _____ Months _____ Years
What is the applicant's current sobriety plan?	☐ Not Applicable; individual is not currently sober/abstinent (Please describe amount and frequency of current use): _____ ☐ Applicable (Please Describe): _____
Is the applicant reliant on AA/NA (or other longer-term support programs) to remain sober/abstinent? **List the average number of meetings per week/month.*	☐ Yes ☐ No Applicant attends _____ meetings each _____
If the above answer is "Yes," then what is the longest time the applicant has gone without a meeting and what was the result?	

E. Past & Current Mental Health/Substance-Related Hospitalizations & Treatment

Past Treatment? ☐ Yes ☐ No Date(s): _____ **From intake to discharge* If "Yes," please describe context/reasons. _____ _____	Current Treatment? ☐ Yes ☐ No Date: _____ **Intake* If "Yes," please describe context/reasons. _____ _____	Hospitalizations? ☐ Yes ☐ No Date(s): _____ **From intake to discharge* If "Yes," please describe context/reasons. _____ _____

F. Past & Current Risk Assessment/Information

Suicide Attempt? ☐ Yes ☐ No Date(s): _____ If "Yes," please describe context(s) and outcome(s). _____ _____ Risk of Recurrence (Check One): ☐ None/Unlikely ☐ Possible/Likely *Describe:* _____ _____ _____ ☐ I am unable to assess this	Suicidal Gesture? ☐ Yes ☐ No Date(s): _____ If "Yes," please describe context(s) and outcome(s). _____ _____ Risk of Recurrence (Check One): ☐ None/Unlikely ☐ Possible/Likely *Describe:* _____ _____ _____ ☐ I am unable to assess this	Suicidal Ideation? ☐ Yes ☐ No Date(s): _____ If "Yes," please describe context(s) and outcome(s). _____ _____ Risk of Recurrence (Check One): ☐ None/Unlikely ☐ Possible/Likely *Describe:* _____ _____ _____ ☐ I am unable to assess this	Self-Injurious Behaviors? ☐ Yes ☐ No Date(s): _____ **From start to remittance* If "Yes," please describe context(s) and outcome(s). _____ _____ Risk of Recurrence (Check One): ☐ None/Unlikely ☐ Possible/Likely *Describe:* _____ _____ ☐ I am unable to assess this

G. Clinical Assessment

AUDIT or Other Tests/Measures Administered:
Please attach pertinent reports or summaries, if any

1. _____

2. _____

To the best of your ability, describe the applicant's ego strength, emotional stability, and flexibility:

_____

_____

_____

To the best of your ability, describe the applicant's coping strategies:

_____

_____

_____

To the best of your ability, describe the applicant's overall functioning (interpersonal and work) and prognosis based on your clinical observations:

_____

_____

_____

_____

_____

What is the applicant's plan for sobriety/abstinence while serving in the Peace Corps?

_____

_____

_____

To the best of your ability, rate and describe the applicant's risk of relapse in a stressful overseas environment ***(characterized by isolation, lack of structure, and limited social supports)***:

☐ High/Likely ☐ Possible ☐ Low/Unlikely

_____

_____

_____

H. Recommendations & Follow Up

What specific recommendations for substance-related support do you have regarding the management of this applicant's condition over the next three years? All recommendations will help determine the best placement for the Peace Corps applicant.

_____

_____

_____

Any other comments or concerns related to the information provided on this form or regarding this applicant?

_____

_____

_____

I certify this information is, in my opinion, an accurate representation of the baseline status of this substance-related condition for the applicant listed above.

Mental Health Provider's Signature: _____

Date: _____