Peace Corps must fully and accurately understand the current health of potential Volunteers and assess whether we can appropriately support and accommodate their individualized health care needs.

This individual has applied to serve as a Peace Corps Volunteer and has reported a history of a mental health condition, counseling, and/or use of a medication related to a mental health condition.

During Peace Corps service, a Volunteer may be placed in a community that is very isolated and remote with a history of high crime, violence, extreme poverty, and/or inequitable treatment of members of the population. There may be limited access to Western-trained mental health professionals and little support for existing or new mental health symptoms. Please take these factors into consideration when completing this form.

Provider Instructions:

* Please complete the form in its entirety and mark N/A if not applicable.
* If you have questions, please contact the Peace Corps Medical Office at 202-692-4047 or pre-serviceunit@peacecorps.gov.
* Return the form to the individual **or** by confidential fax to the Peace Corps Medical Office at 202-692-1561.

**Applicant Name (Last, First): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mental Health Provider’s Name & Degree (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Form Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

This individual is:

Currently engaged in counseling/treatment:

🞎 With me (the provider) or my practice

🞎 With another provider

Or

Previously engaged in counseling/treatment:

🞎 With me (the provider) or my practice

🞎 With another provider

Have you received mental health reports of prior treatment for this individual? 🞎 Yes 🞎 No

If “No” or if documentation is insufficient, please inquire fully about the individual’s mental health treatment history.

Date range of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency of sessions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were there gaps in treatment? 🞎 Yes 🞎 No

If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is treatment ongoing? 🞎 Yes 🞎 No

 If no, date of termination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was termination satisfactory and/or mutual? 🞎 Yes 🞎 No

If no, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please identify treatment modality:

Treatment plan, individual’s reaction to treatment, and other relevant clinical information:

Other current treatment not listed above, including dates:

1. **Clinical Disorders**

**Mental Disorders and Conditions**

|  |  |  |  |
| --- | --- | --- | --- |
| **Diagnoses (past and current)*****Ex: Generalized Anxiety Disorder, Major Depressive Disorder, etc.*** | **Date Given** | **Date Remitted** | **Ongoing**  |
|  |  |  | 🞎 Yes 🞎 No |
|  |  |  | 🞎 Yes 🞎 No |
|  |  |  | 🞎 Yes 🞎 No |
|  |  |  | 🞎 Yes 🞎 No |

**Mental Health Symptoms**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Symptoms (past and current)*****Ex: depressed mood, panic attacks, etc.***  | **Onset** | **Severity** | **Duration** | **Date Remitted** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Co-existing Medical Disorders:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Diagnoses*****Ex: insomnia, chest pain, thyroid disease, etc.***  | **Date Given** | **Date Remitted** | **Ongoing**  |
|  |  |  | 🞎 Yes 🞎 No |
|  |  |  | 🞎 Yes 🞎 No |
|  |  |  | 🞎 Yes 🞎 No |
|  |  |  | 🞎 Yes 🞎 No |

1. **Psychosocial/Contextual Factors (past and current):**

Please identify any relevant concerns, related to the following: primary support group, social environment, housing/living situation concerns, education/work concerns, economic concerns, legal concerns, cultural/environmental concerns, and any other factors. Indicate beginning date and date remitted, or ongoing, if applicable.

1. **Assessment of Functioning (past and current):**

Please identify any concern, regarding the follow areas: self-care, social functioning, and activities of daily living. Indicate date given and date remitted, if applicable.

1. **Mental Health Hospitalizations (residential, inpatient, partial, and intensive outpatient):**

Has the individual ever received intensive treatment or hospitalization? 🞎 Yes 🞎 No

If yes, explain and provide date(s).

1. **Risk Assessment & Related Information (past and current):**
2. Has this individual ever attempted suicide? 🞎 Yes 🞎 No

If yes, explain and provide dates, contexts, and outcomes:

Risk of recurrence (check one): 🞎None/Unlikely 🞎Possible/Likely 🞎Unable to assess

Describe:

1. Has this individual ever made a suicidal gesture? 🞎 Yes 🞎 No

If yes, explain and provide dates, contexts, and outcomes:

Risk of recurrence (check one): 🞎None/Unlikely 🞎Possible/Likely 🞎Unable to assess

Describe:

1. Has this individual ever had suicidal ideation? 🞎 Yes 🞎 No

If yes, explain and provide dates, contexts, and outcomes:

Risk of recurrence (check one): 🞎None/Unlikely 🞎Possible/Likely 🞎Unable to assess

Describe:

1. Has this individual ever engaged in self-injurious behaviors? 🞎 Yes 🞎 No

If yes, explain and provide dates, contexts, and outcomes:

Risk of recurrence (check one): 🞎None/Unlikely 🞎Possible/Likely 🞎Unable to assess

Describe:

1. **Treatment History:**

Has the individual engaged in previous outpatient counseling/treatment? 🞎 Yes 🞎 No

If yes, explain and provide date(s).

1. **Psychotropic Medications (past and current):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication and Dosage** | **Start Date** | **End Date** | **Response to Medication** | **Recommended Monitoring Plan** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

1. **Clinical Assessment**

Psychological tests/measures administered with scores:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To the best of your ability, describe the individual’s:

1. Emotional stability, flexibility and overall functioning
2. Coping strategies given the resource-limited environment available to Peace Corps Volunteers
3. Risk of symptom recurrence in a stressful overseas environment (characterized by isolation, lack of structure, and limited social supports): 🞎High/Likely 🞎 Possible 🞎 Low/Unlikely
4. **Recommendations & Follow Up**
5. What specific recommendations for mental health support do you have regarding the management of this individual’s condition over the next three years? All recommendations will help determine the best placement for the Peace Corps applicant.
6. Do you have any other comments or concerns related to the information provided on this form or regarding this individual?

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

**Mental Health Provider’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**License No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_**

**Practice Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**