Form Approved
OMB No. 0920-0006
Exp. Date: xx/xx/xxxx

FOLLOW UP OF IMMIGRANTS OR REFUGEES WITH CLASS A PHYSICAL OR MENTAL CONDITION

This will satisfy the agreement of health care provider to document that he/she supplied counseling and any treatment or observation necessary for the proper management of the alien's mental disorder

NAME OF PATIENT: _________________________________Date of Birth __________
Mo/ da / year

Sex Male Female Country of Birth_______________

Race___________________ Ethnicity: _______________________

Date of Patient's first visit______________Date of most recent visit______________
Mo/da/year Mo/da/year

Nature of Visit: Substance abuse or addiction disorder yes no
Other mental disorder yes no

Current Diagnoses:

Axis I____
Axis II____
Axis III____
Axis IV____
Axis V____

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing 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 CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0006).

Current Status:

Is the patient a danger to self? yes ☐ no ☐

to others? yes ☐ no ☐

Does patient require treatment? yes ☐ no ☐

If follow up treatment is recommended, will patient remain under your care? yes ☐ no ☐

If no, are you referring to another specialist? yes ☐ no ☐

If yes, give name and address of specialist____

Has the patient followed treatment as prescribed, including any medications, keeping appointments, getting necessary laboratory work, psychoeducation or psychotherapy ?
yes ☐ no ☐

Treatment recommended Yes ☐ No ☐. If yes, what is the current treatment plan____
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1.
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Printed or typed name of current physician____

Mailing address________________________________City_________________State______

Zip______________ Phone ( )_____________Fax ( )_________________

Signature____Date________________________

CDC 4.422-1a