Patient's Name: _____
Sex Assigned at Birth: _____

CONFIDENTIAL MENTAL AND BEHAVORIAL HEALTH FORM

To be completed *by all mental health clinician(s)* if there is any recent mental health history (within the past two years or if currently receiving treatment). These mental health clinicians may include: Psychiatrist, Nurse Practitioner, Psychologist, or any other Licensed Psychotherapist, or Mental or Behavioral Health Professional.

Final acceptance and project assignments are dependent on completion, submission, and assessment of this form. AMIGOS reserves the right to have the designated Mental Health Consultant speak directly with an applicant or volunteer's mental health clinician and/or legal guardian(s) for assessment.

Attention Applicants & Parent/Legal Guardians:

- Please review the following "Mental Health Criteria" to ensure that the criteria is met for participation:
    - No acute psychiatric diagnosis or episode, or psychiatric hospitalization within the past year, prior to the current application to AMIGOS.
    - No new *psychotropic medication(s) within six months of departure for country assignment.
    - No major changes of existing psychotropic medication(s), including sudden stoppage, within three months of departure for country assignment.
    - Relative stability (verified by the treating clinician) over the last year, if a history of chronic depression, anxiety, or other psychological or behavioral diagnoses exists. Some diagnostic categories will be ruled out depending on AMIGOS' assessment as to whether these volunteers constitute more risk for health and safety than the Project Staff Team can manage.
    - Willingness by the volunteer to sign a Self-Care Agreement which holds them accountable for administering their own prescribed medication(s) (antidepressant, stimulant, anti- anxiety agent, etc.) and monitoring their mental health, reporting immediately any new or familiar symptoms.

  *Psychotropic medication: Any medication capable of affecting the mind, emotions, and behavior such as antidepressant/anti-anxiety agents, antipsychotic drugs, mood stabilizers, anticonvulsant medication, stimulants for the treatment of ADHD, etc.

- **If currently or during the past two years, you received outpatient mental health, inpatient psychiatric, or chemical dependency services, a copy of the Mental Health Clinician(s) Form must be completed by ALL treating clinicians and their signature and full contact information must be included at the bottom of this form.**
- It is important that your mental health care provider be aware of the rural, sometimes under-developed conditions in which our volunteers might live and, therefore, indicate any condition(s) which may affect your participation.
- Any additional forms your clinician(s) wish to include may be attached; however, **this form must be completed in full by each treating mental health clinician.**

Attention Clinician:
Your patient is requesting to participate in Amigos de las Américas for a period of up to 6 weeks (for volunteer applicants), 3-4 months (for Project Staff Team applicants), or up to 9 months (for Gap Program applicants). The AMIGOS Program can be physically and emotionally challenging. Volunteers must be able to function relatively independently under stressful conditions using Spanish as their main language. They will be supervised by adults who are not mental health professionals, but mentors and guides. Conditions the volunteers might face include, but are not limited to, the following:

- rudimentary living conditions;
- lack of clean, disinfected water;
- extreme climatic conditions which may include heat, cold, high altitude, and long periods of rain;
- a dramatically different diet; and
- different and stressful cultural settings which may be emotionally challenging.

Additionally, mental health services will not be immediately available and might not be available at a level equivalent to those in the United States or the volunteer's country of origin. Disclosure of a mental health condition does not automatically disqualify an applicant from admission to the program but might result in further screening to determine the appropriateness for AMIGOS service. Non-disclosure is grounds for dismissal from the program at any time.

This report is reviewed by AMIGOS staff members as well as mental health professional consultants and copies are available for review by staff. Please return this form to your patient for submission to our National Office.

If you have any questions about this form and/or AMIGOS, call 713-782-5290 x115 (or toll free at 1-800-231-7796) and ask to be connected with the Director of Health and Safety or send an email to healthandsafety@amigosinternational.org. For additional information about AMIGOS please visit our website: amigosinternational.org

*Note: Any substantial change in your patient's mental and/or emotional health or current medication(s) prior to their departure should be reported promptly to:

Director of Health and Safety
Amigos de las Américas
1800 West Loop South Ste., 1325
Houston, Texas 77027 USA

Initials: _____

*** ***All treating mental health clinicians must fill out a copy of the Confidential Mental Health Form. The health screening process will not be complete until all requested health information has been completed by all treating clinicians. Please make sure the clinician's required release of information forms are signed by this patient or legal guardian in order to more quickly and efficiently complete the process.***

1. What is your patient's current working diagnosis?

2. Has your patient ever had a diagnosis of, received outpatient treatment for, or been hospitalized for:

_____ Anxiety

_____ Panic Attacks

_____ Depression/Mood Disorder

_____ Suicide Attempt

_____ Bipolar Disorder

_____ Obsessive Compulsive Disorder

_____ Psychosis

_____ Eating Disorder (Anorexia/Bulimia)

_____ Attention Deficit Hyperactivity Disorder

_____ Substance Abuse/Chemical Dependency

_____ Other Psychiatric/Emotional Disorder *(please describe)*

For each psychiatric condition, record all applicable letters:

X = No history of this condition

D = Diagnosis without treatment

T = Outpatient Treatment (concluded)

T/C = Outpatient Treatment (current)

H = Hospitalization/Please include date(s)

2. If your patient has a history of any condition listed above in (1), please answer the following questions for each condition. *(Please copy this section for each additional condition)*

a. What was/is the nature of the condition?

Dates of active illness/Periods of remission:

Initials: _____

Symptoms:

Severity:

b. What was/is the nature of the treatment?

c. Modalities used:

Initials: _____

d. Please list here any psychotropic medication currently being used as part of the treatment plan. Include medication, dosage, and date started.

Medication Name	Dosage (e.g. 5mg)	Frequency (e.g. 2x/day)	Date Medication started (e.g. 1/1/2013)	Side Effects (include potential)	Name and Credentials of Prescriber (Psychiatrist, PCP…) (e.g. Dr. Jones, Psychiatrist)	Reason for Taking	Will take medication during AMIGOS Latin American service program?
							Yes No
							Yes No
							Yes No
							Yes No
							Yes No

e. Level of Compliance

3. Do you endorse your patient's participation cultural immersion program in Latin America away from their usual family & social support network, & with an interruption of their ongoing psychiatric and/or psychological care?

Yes_____ No _____

4. On a scale from 1-5, how would you rate your patient's emotional coping skills? (1 being the lowest, 5 being the highest)

1 2 3 4 5

Please add here any additional comments.

5. I have attached additional physician/clinician's notes.

Yes_____ No_____

6. I would like to talk privately with an AMIGOS representative to obtain more detailed information on the program demands.

Yes _____ No_____

Initials: _____

7. What were the dates of your treatment of this patient?

Starting_____ Ending/ Current _____ (circle)

* A separate form should be completed & signed for each Mental or Behavioral Health Clinician (psychotherapist, psychologist, psychiatrist, etc.)

Mental Health Clinician's Signature _____Date _____

Clinician's Name (please print) _____

Street Address _____City _____

State _____ Zip Code _____ Phone (_____)_____

Applicant Signature_____Date_____

Parent/Guardian Signature (if under 18) _____Date_____