

INSTRUCTIONS FOR TREATMENT PROVIDER INFORMATION (TPI)

- **Going back 7 years, or since your last medical clearance update:** Please have any health practitioner, psychotherapist, licensed social worker or counselor, who has evaluated or provided treatment for a mental health concern, complete the attached form. Treatment refers to medications and/or therapy for mental health concerns. If you have ever been hospitalized as an inpatient, or attended a partial or day treatment program or IOP (intensive outpatient program), for mental health concerns, please send a copy of the admission and discharge summaries for those periods instead of this form.
- **Please use the following cover sheet** to send the information to Medical Records.
- NOTE: *If possible please scan medical documents into a PDF format document and send to Medical Records as an e-mail attachment.* This is the preferred method to send information to Medical Records. Please send to MedMR@state.gov
- Please provide the requested information within **two weeks** or, if you have been unable to obtain information, discuss alternatives with Mental Health Services (MHS) Nurse Case Manager (202-663-3949/ MEDMHS@state.gov)
- If MHS has not received the requested information within six weeks, or you have not contacted MHS, MHS may close your file without a recommendation to Medical Clearances.

If completing this TPI form incurs expenses from the provider not reimbursed by your health insurance, please submit your health insurance denial (including Explanation of Benefits Statement, itemized bill, and 616 authorization form) to:

OFFICE OF MEDICAL SERVICES
 MEDICAL CLAIMS SECTION
 2401 E. STREET, N.W., ROOM 101
 WASHINGTON, D.C. 20522-0101

	Révision #	Date	Author	Clearance	Reason for Revision
4004.6	0	02/12/07	PAG	PAG	
	9	12/07/12	RMK	SMW	Instructions clarified & signature/identifier revised
	10	1/27/14	JSK	JHR	Reviewed and revised

US Department of State
Office of Medical Services
Mental Health Services
Phone: 202-663-1903
FAX: 703-875-4850

e-mail transmittal form and instructions

To: Medical Records for MHS

e-Mail: MedMR@state.gov

From:

Date:

Your
Name

Total Pages:

(Including this page)

Phone number:

- ❑ NOTE: *If possible please scan medical documents into a PDF format document and send to Medical Records as an e-mail attachment. This is the preferred method to send information to Medical Records.*
Send to: MEDMR@state.gov

Medical Confidentiality Notice: Documents accompanying this facsimile transmittal contain medically confidential information, belonging to the sender that is legally protected. This information is intended only for use of the individual or entity named above.

If you are not the intended recipient, you are hereby notified that any disclosure, copying distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this facsimile transmittal in error, please notify the sender immediately to arrange for the return of these documents.

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TREATMENT PROVIDER INFORMATION (TPI)

United States Department of State
Office of Medical Services

INSTRUCTIONS FOR THE PROVIDER: Please be candid when providing answers to these questions. There are many assignments where the patient will be isolated, may be exposed to crime, terrorism, extreme poverty, or inequitable treatment and where there are no competent mental health professionals, no Western-trained physicians or very poor medical resources. Many posts are in very remote areas or in war zones. It WOULD NOT be in the patient's ultimate interest were he/she to be assigned to a position, post, or area that cannot support his/her mental health needs or recommendations. Your contribution is greatly appreciated. If space is inadequate, please feel free to continue your answers on an additional page. If preferred, a narrative summary addressing these questions may be substituted and/or attached.

PATIENT NAME: _____ **DATE OF BIRTH:** _____

1. DATE of initial contact/consultation: _____ **DATE of last treatment contact:** _____

Is treatment ongoing? Yes No Comment _____

2. PRESENTING SYMPTOMS: Y=Yes, N=No, U=Unsure/Unknown

Depressed Mood	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Drugs/Alcohol Misuse	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Grief Reaction	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>
Loss of pleasure	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Increased Irritability	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Hyperarousal	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>
Decreased Energy	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Increased Anxiety	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Reexperiencing Event	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>
Change in Appetite	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Panic Attacks	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Hypomanic/Manic	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>
Sleep Problems	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Agoraphobia	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Somatic Symptoms	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>
Suicidal Ideation	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Obsessions/Compulsions	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Inattentiveness	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>
Self Injurious Behavior	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Avoidant Behavior	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Work/School Problems	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>
Homicidal Ideation	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Hallucinations/Delusions	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Relationship Problems	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>
Aggressive Behavior	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Purging/Laxative Abuse	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Severe Wt Loss/Dieting	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>

Add additional presenting symptoms/issues/concerns: _____

PSYCHOSOCIAL STRESSORS: _____

IF SI/HI PRESENT, SPECIFY CIRCUMSTANCES (SEVERITY, FREQUENCY, CAUSE, ETC): _____

3. INITIAL DIAGNOSTIC IMPRESSION: Provide DSM or ICD Diagnostic Codes, if known

Pertinent Medical Hx: _____

4. PAST HISTORY OF:

Aggressive Behavior	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Psychosis	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Hypomanic/Manic	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>
Impulsive Behaviors	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Reexperiencing Event	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Alcohol Misuse	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>
Suicidal Ideation or Behavior	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Self Injurious Behavior	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Street Drug/Prescription Misuse	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>
Homicidal Ideation	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Impaired Judgment	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Trauma/Abuse	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>

5. PAST TREATMENT:

Hospitalization YNU Dates: _____
 Day Treatment YNU Dates: _____
 Psychotherapy YNU Dates: _____

Past Psychotropic Medication(s) Names and Dates when known: _____

Past Providers if known: _____

IF PAST SI/HI OCCURRED, SPECIFY CIRCUMSTANCES: _____

6. CURRENT/ MOST RECENT COURSE OF TREATMENT:

a. PSYCHOTHERAPY: Individual Y N Couples Y N Other _____ Y N

Initial Frequency of sessions: _____ Current Frequency of Sessions: _____

Total number of sessions to date: _____

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b. MEDICATION: Name	Dose	Dates (Start & Stop)	Current Use
_____	_____	_____	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>
_____	_____	_____	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>
_____	_____	_____	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>
_____	_____	_____	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>
_____	_____	_____	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>

Initial Frequency of med monitoring: _____ Current Frequency of med monitoring: _____

c. **Names of other current mental health providers:** _____

7. **ADHERENCE/COMPLIANCE** with treatment: _____

8. **INSIGHT** into illness and its effect on function/**JUDGMENT** regarding seeking treatment: _____

9. **OUTCOME: Diagnoses at Last Contact** – Provide DSM or ICD Diagnostic Codes, if known: _____

Level of Remission (Full, Partial, Minimal): _____

Response to Psychotherapy: _____

Date of Most Recent Medication Change (either change in medication or dosage): _____

Reason for Most Recent Medication Change: _____

10. **ACTIVE SYMPTOMS at Last Contact:** Y=Yes, N=No, U=Unsure/Unknown

Depressed Mood	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Drugs/Alcohol Misuse	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Grief Reaction	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>
Loss of pleasure	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Increased Irritability	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Hyperarousal	Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>
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Add additional symptoms/issues/concerns: _____

IF RECENT SI/HI PRESENT, SPECIFY CIRCUMSTANCES: _____

11. **SUPPORTS: What** Mental Health Support is recommended and at what frequency? (Examples: Child Psychiatrist q 3 months, Primary Care Provider annually, Psychotherapist weekly) _____

Will you be able to provide the recommended Mental Health Support while the patient is overseas? Yes No

Comments: _____

12. **STRESSORS: Are** there any concerns that you have pertaining to patient's capacity to withstand the stress of a Foreign Service lifestyle? Please remember the austere conditions and lack of medical services in many locations. (Please see Instructions for the Provider) _____

How great is the risk for harm or relapse to target symptoms (check appropriate box), if this patient were assigned to

- | | |
|---|---|
| <p>a. High conflict area/war zone for 1-2 years</p> <p><input type="checkbox"/> no more risk than would be expected for the average person in this environment</p> <p><input type="checkbox"/> marginally higher risk</p> <p><input type="checkbox"/> considerably higher risk</p> <p><input type="checkbox"/> cannot assess risk</p> | <p>b. Very remote area or austere location many days away from the nearest MH support for 2-3 years</p> <p><input type="checkbox"/> no more risk than would be expected for the average person in this environment</p> <p><input type="checkbox"/> marginally higher risk</p> <p><input type="checkbox"/> considerably higher risk</p> <p><input type="checkbox"/> cannot assess risk</p> |
|---|---|

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13. Additional Comments:

PROVIDER'S NAME, DEGREE and SPECIALTY: (please print) _____

LOCATION/ADDRESS: _____

CONTACT TELEPHONE NUMBER: _____

SIGNATURE/ DATE: _____

PATIENT AUTHORIZATION TO RELEASE INFORMATION: I the undersigned, hereby authorize the provider(s) listed above to release protected health information as may be requested by Mental Health Service (MHS) of the Office of Medical Services U.S. Department of State (DOS). I authorize representatives of MHS from the Office of Medical Services US DOS to communicate with and release information to the above providers. I understand that this information will be used in determining a medical clearance. I am familiar with the US Department of State Office of Medical Services NOTICE OF PRIVACY PRACTICES.

Patient's/Parent's/Guardian's Signature: _____ **Date:** _____