



Name (First & Last): _____

Confidential Health Form II (CHF-II)

(To be completed by physician/clinician)

Attention Participant & Parent/Legal Guardian:

- If during the past two years you received outpatient mental health, inpatient psychiatric, or chemical dependency services, a copy of this form must also be completed by those treating clinicians.
- It is important that your physician/clinician be aware of the rural, sometimes under-developed conditions in which participants may live and indicate any condition that may affect your participation.
- Any additional forms your physician/clinician(s) wish to use may be attached; however, this form must also be completed in full.

Attention Physician/Clinician:

Your patient is requesting an examination to participate in Amigos de las Américas for a period of up to 8 weeks (for Volunteer applicants) or 3-4 months (for Project Staff applicants). Please be remind **your patient that he/she must receive all vaccinations and necessary project-specific prophylaxis (e.g. anti-malarial medication) required by AMIGOS. The updated list of required inoculations and medications will be released in early spring 2012 once all participant country and project assignments are made.** The AMIGOS Service Program in Latin America can be physically and emotionally challenging. Participants must be able to function relatively independently under stressful conditions using Spanish as their main language. They will be supervised by young adults who are not health professionals. Conditions the participant may face include, but are not limited to, the following:

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

Additionally, medical and pharmaceutical services may not be immediately available and may not be available at a level equivalent to those in the United States or the participant’s country of origin. Disclosure of a medical condition does not automatically disqualify an applicant from admission to the program, but may result in further screening to determine the appropriateness for AMIGOS service.

This medical report is reviewed by AMIGOS and copies are taken to Latin America. Please return this form to your patient for submission to our International Office.

If you have any questions about this form and or AMIGOS, call 713-782-5290 (or toll free at 1-800-231-7796) and ask the Administrative Assistant to connect you with “Volunteer Services”. Or send an email to info@amigoslink.org. Feel free to visit AMIGOS’ website: www.amigoslink.org

Initialed by Clinician: _____



Name (First & Last): _____

(1) Do you consider your patient psychologically stable enough to responsibly handle the stresses of the AMIGOS community assignment in Latin America? *(Please refer to the above "Attention Physician/Clinician" for a description of the AMIGOS Program.)*

Yes No

Comments:

(2) During the AMIGOS Latin American assignment your patient may experience a dramatic change in diet. Has your patient been able to independently maintain adequate nutrition in the past and do you consider that your patient will be able to do so during the AMIGOS Service Program?

Yes No

Comments:

(3) In your judgment as a clinician, please document any mental or physical conditions that are of potential concern for your patient's successful participation in AMIGOS.

****Note: Any substantial change in your patient's medical and/or emotional health prior to his/her departure for the Latin America community assignment should be reported promptly to:***

Volunteer Services
Amigos de las Américas
5618 Star Lane
Houston, Texas 77057 USA

Initialed by Clinician: _____



Name (First & Last): _____

MEDICAL HISTORY

Medications

(1) Please list **all** prescription, over-the-counter, and natural medications your patient is currently taking. Make a note that you have written on the back of this form if additional space is needed.

Medication Name	Dosage (e.g. 5mg)	Frequency (e.g. 2x/day)	How long has medication been prescribed? (e.g. 6 months)	Side Effects (include known & potential)	Reason for Taking	Will take medication during AMIGOS Latin American service program?
						Yes <input type="checkbox"/> No <input type="checkbox"/>
						Yes <input type="checkbox"/> No <input type="checkbox"/>
						Yes <input type="checkbox"/> No <input type="checkbox"/>
						Yes <input type="checkbox"/> No <input type="checkbox"/>
						Yes <input type="checkbox"/> No <input type="checkbox"/>

(2) Do you consider your patient to be stable on their current medications?

Yes No

Comments:

(3) Do any medications require constant refrigeration or frequent adjustments and monitoring?

Yes No

Comments:

(4) Do you consider your patient capable of caring for and administering his/her own medication as prescribed?

Yes No

Comments:

Initialed by Clinician: _____



Name (First & Last): _____

Allergies

- (1) Include medicines, foods, animals, insect bites and stings, and environment (dust, pollen, etc.) or select No known allergies.

Allergy	Reaction	Medication Required (e.g. EpiPen), if any	Will take medication during AMIGOS Latin American service program?
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>

- (2) Describe the severity of your patient’s allergies.

Other Conditions

Please list any medications related to the below conditions on the previous page.

- (1) Does your patient have any (or have a history) of the following conditions? (*check the appropriate boxes*):

	YES	NO
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Any orthopedic/neurologic condition that impairs your patient’s mobility	<input type="checkbox"/>	<input type="checkbox"/>
Any congenital medical conditions (e.g. congenital heart disease)	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Altitude sickness	<input type="checkbox"/>	<input type="checkbox"/>
Recent physical injury or disability (causing any limitations in walking long distances, lifting objects, doing construction tasks, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Any other health condition that may need to be taken into consideration	<input type="checkbox"/>	<input type="checkbox"/>

- (2) If you answered “yes” to any of the above, please explain the severity of each of your patient’s condition(s).

Initialed by Clinician: _____



Name (First & Last): _____

MENTAL HEALTH HISTORY

Please check if the primary care physician or participant's mental health professional is completing this section.

**** If an individual other than the primary care physician is completing this section, please also include complete contact information on the next page along with the physicians.**

(1) 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

(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:

Symptoms:

Severity:

(b) What was/is the nature of the treatment?

Dates:

Modalities used:

If a medication is prescribed currently, please add it to the medication table in the medical history section of this form.

Level of compliance/Response to treatment:



I have attached additional physician/clinician's notes.

Yes No

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

Yes No

Primary Care Physician's Signature _____ Date _____

Physician's Name (please print) _____

Street Address _____ City _____

State _____ Zip Code _____ Phone (_____) _____

Other Treating Clinician's Signature _____ Date _____

Clinician's Name (please print) _____

Street Address _____ City _____

State _____ Zip Code _____ Phone (_____) _____