Confidential Medical Report

Notes:

- **To be completed by the applicant's Psychiatrist or G.P.**
- We would be grateful if you could complete the following report on behalf of the applicant for service.
- For ease of reading, please fill this form using BLOCK LETTERS.
- All application documentation comprising of Authorisation Form, Application Form, Rehabilitation Profile and Confidential Medical Report must be completed before the application can be processed.

Applicant's Details	Psychiatrist's/G.P. Name and Contact Details
Name:_____	Name: _____
Address:_____	Address: _____
_____	_____
Date of Birth: _____	Phone No: _____

Psychiatric Diagnostic Information

Psychiatric Diagnosis - ICD 10 Code No: 1 ☐☐☐☐☐ 2 ☐☐☐☐☐

or DSM IV: 1 ☐☐☐☐☐ 2 ☐☐☐☐☐

Psychiatric Diagnosis:_____

Description of illness: _____

Date of Onset of illness:_____

Is the patient on any medication which may or does effect his/her performance in everyday tasks e.g. tremor, eyesight, drowsiness? If yes, please describe: _____

_____

_____

_____

What are the everyday problems of his/her illness or disabilities? _____

_____

_____

_____

Are there any symptoms of relapse? (Please describe): _____

_____

_____

_____

_____

Is there a pattern to this person's relapse? (If yes, please describe): _____

_____

_____

_____

_____

In the past six months what time has this person spent in a Day Service/In-patient Care?

_____

_____

_____

_____

Please indicate interventions and their outcomes to date (e.g. Rehabilitation, Medical, Psychotherapeutic):_____

_____

_____

_____

Are there any other facts pertinent to this person's Rehabilitation Plan?

_____

_____

_____

_____

_____

Has this person been psychologically assessed? Yes ☐ No ☐ Don't know ☐

If yes, please include the psychological report and/or name and address of relevant Psychologist:

Name:_____

Address:_____

_____

Has this person been assessed by any other professional i.e. Social Worker, Occupational Therapist: Yes: ☐ No: ☐ If yes, please include their details below:

Name:_____ Name:_____

Address:_____ Address:_____

_____ _____

Other Medical Conditions

Does the applicant have any other medical conditions that the service should be aware of e.g. epilepsy, allergies etc. (Please describe):

_____

_____

_____

Problem Behaviour

Is there a history of:

	Yes	No
Fire Setting	☐	☐
Inappropriate Sexual Behaviour	☐	☐
Suicidal Behaviour	☐	☐
Alcohol / Drug Abuse	☐	☐
Aggressive / Violent Behaviour	☐	☐

If yes, please provide specific details:_____

_____

_____

_____

_____

_____

Further Information

Is there any further information you feel may help meet this person's rehabilitation needs?

_____

_____

_____

_____

_____

_____

We would like to thank you for your help in completing this form.

This form may be copied to the relevant appointed authority of the Health Service Executive in order to assess the applicant's eligibility for funding.

Signed: _____ Date: _____

Name and title in BLOCK LETTERS please _____

If you are clear about the EVE service you wish to refer the applicant to, please send the completed form to the relevant Centre Manager.

EVE also provides an Advisory Team which meets on a fortnightly basis. The role of this team is to establish the best fit between the requirements of the person and the service network provided by EVE. If you prefer to use this service, please send the completed form to the Applications Manager at EVE, Brú Chaoimhín, Cork Street, Dublin 8.