

PRE-ENROLLMENT QUALIFICATION ASSESSMENT TOOL FOR MENTAL ILLNESS (HMO CSNP)

First Name:	MI:	Last Name:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	DOB:	

CLINICAL QUALIFYING QUESTIONS

If any of the following are checked, candidate pre-qualifies.

Have you ever been told by a doctor that you have any of the following illnesses? (Check all that apply)

- Major Depression
- Bipolar Disorder
- Schizoaffective Disorder
- Paranoid Disorder
- Schizophrenia

MEDICATION QUESTIONS

1. Are you now or have you ever taken medication for an illness listed above? Yes No

2. What medications are you currently taking? _____

PRIMARY PHYSICIAN: _____
Name of Physician

His/her clinic or location and phone number

PSYCHIATRIST: _____
Name of Psychiatrist

His/her clinic or location and phone number

SPECIALIST: _____
Name of Specialist

His/her clinic or location and phone number

Candidate Signature:	Date:
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