**CHRONIC CARE MANAGEMENT PLAN**

**TOURETTE’S DISORDER**

**[To be completed by a licensed mental health provider, physician or other licensed health provider.]**

Please provide the following information on the applicant’s self-disclosed diagnosis of Tourette’s Disorder. The information provided will be used to assist Job Corps staff in determining the applicant’s health care needs and ability to successfully participate and benefit from the Job Corps program.

All information released will be handled in the strictest confidence and forwarded to the appropriate licensed health and wellness staff for evaluation and review. A copy of your patient’s authorization to release the requested information is enclosed.

1. What are the current symptoms? \_\_\_\_

1. What is the severity level of the motor and vocal tics?

[ ]  Mild intermittent—symptoms absent with medication

[ ]  Mild persistent—symptoms more than twice a week, less than daily

[ ]  Moderate persistent—daily symptoms that interfere with daily activities

 [ ]  Severe, persistent—continual symptoms, even with compliance

1. Date of diagnosis: Age of onset:
2. When was last appointment?
3. List **current** (within the past 6 months) self-harm behaviors and/or harm to others and/or property.

1. a. List current medications including dosage and frequency. \_

b. Has applicant been adherent with medications? If no, explain.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Will the applicant be able to self-manage medications with minimal supervision? If no, please explain.

1. a. List applicant’s other treatments including frequency and adherence.

b. Has applicant been adherent with other treatment(s)? If no, explain. \_\_\_\_\_\_\_\_\_\_\_\_\_

1. List past hospitalizations, including dates, and reason for admission.

1. What is the current status of applicant’s condition?

1. What is the applicant’s prognosis with treatment and/or medication?

1. What is the applicant’s prognosis **without** treatment and/or medication?

1. Will the applicant need follow up care? [ ]  YES [ ]  NO
* Continue follow up under your care? [ ]  YES, next appointment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  NO
* Follow up with another provider (PCP, psychiatrist, therapist—*circle as needed*)[ ]  YES [ ]  NO
* Recommended frequency of follow-up:
1. Does the applicant currently require any of the following services? (**Note:** These services are NOT services provided ON center by Job Corps.)

|  |  |  |  |
| --- | --- | --- | --- |
| Day treatment program | [ ]  Yes[ ]  No | Partial hospitalization program | [ ]  Yes[ ]  No |
| Long term individual counseling | [ ]  Yes[ ]  No | Therapeutic residential program | [ ]  Yes[ ]  No |
| Group therapy | [ ]  Yes[ ]  No | Substance abuse treatment | [ ]  Yes[ ]  No |
| Intensive outpatient program | [ ]  Yes[ ]  No | Other:  | [ ]  Yes[ ]  No |

1. Are there any restrictions or limitations related to this specific condition?

1. List any challenging behaviors demonstrated by the applicant.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. List any accommodations you think are necessary for this applicant to participate in a vocational training program?

**PLEASE READ:** Job Corps is a residential career and academic training program where students at most centers live in non-mental health dormitory-style residences with considerable periods of unsupervised time after 3:30 pm and free weekends. Students are expected to have independent living skills and not demonstrate behaviors that can impede the learning of others. Minimal, short-term mental health services are available on center. Most centers do not have full-time mental health professionals.

In your professional opinion, are the applicant’s symptoms and behaviors sufficiently well-managed and are expected to remain stable enough to participate in the Job Corps program with limited supervision after the training day and on weekends? [ ]  Yes[ ]  No Please explain.

**Please sign below and return the form in the attached addressed envelope.**

###### Print Name and Title of Licensed Health Provider Signature

###### Phone Date

For any questions, please call:

 Admission Counselor/Health and Wellness Staff Phone