# People Who Have Psychiatric Disabilities

# Access Information Form

This form has 22 questions about your daily living as someone who has, or may have, a psychiatric disability. Each question has a space afterwards to type in the response. This information will help start our discussions with you in planning for any access or resources you will need while on the international program; it is not meant to diagnose or create a treatment plan.

**Confidentiality:**

You are not required to answer any or all of these questions. Information that you provide on this form will remain confidential and will be used to ensure your full participation in the international exchange program.

**Alternate Formats:**

If you would like to provide or receive information other than in this form, such as:

* In-person interview
* Conversation via phone or video
* Other formats

Contact \_\_\_\_\_\_\_\_\_\_\_\_ at \_\_\_\_\_\_\_\_\_\_\_\_ to make arrangements.

**Questions:**

All questions or concerns can be directed to \_\_\_\_\_\_\_\_\_\_ at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. (Include phone AND email option)

# Write Your Name:

# DISABILITY OVERVIEW

## In your own words, please describe your disability.

## How does your disability affect you on a day-to-day basis (if at all)?

### What events or behaviors worsen your disability? For example, stress, lack of sleep, large groups, skipping meals, alcohol, etc.

# SERVICES & MEDICATIONS

## Are you participating, or have you participated, in treatment or services related to your mental health? Indicate on the following list services you currently are using and which you have previously used.

### Outpatient treatment/ Talk therapy

### Case management

### Residential services

### Medication management

### Inpatient treatment

### Substance use services

### Emergency services

### Disability Benefits from Governments (e.g. SSI or SSDI for U.S. respondents)

### Medicaid Waiver (U.S. respondents only)

### Representative Payee

### Other (Describe)

## Please list your current prescriptions. Include the name of each medication, the prescribed dosage, and the time of day you typically take each medication.

### First Medication Name:

### Generic? Yes or No

### Dosage Amount:

### How often do you take this medication ? Indicate number times/ day OR as needed

### When do you take this medication? (e.g. morning, evening, with meals, other)

### When does your current prescription expire?

### What side effects do you experience?

### What effects do you experience when you miss a dose?

### Second Medication Name:

### Generic? Yes or No

### Dosage Amount:

### How often do you take this medication ? Indicate number times/ day OR as needed

### When do you take this medication? (e.g. morning, evening, with meals, other)

### When does your current prescription expire?

### What side effects do you experience?

### What effects do you experience when you miss a dose?

### Third Medication Name:

### Generic? Yes or No

### Dosage Amount:

### How often do you take this medication ? Indicate number times/ day OR as needed

### When do you take this medication? (e.g. morning, evening, with meals, other)

### When does your current prescription expire?

### What side effects do you experience?

### What effects do you experience when you miss a dose?

### Please list additional medications on a separate page.

## Are you taking any non-prescription (over-the-counter, herbal, etc.) medications?

## Which of these medications are you planning to bring with you abroad?

# MANAGING DAILY LIVING

## Who is aware of your disability?

### Who do you include in your support network? Will you be able to communicate with them?

### How do you communicate with the people in your support network?

## What are your most effective coping strategies?

## How do variations in your routine affect you (mood, medication compliance, self-care, etc.)?

## In the past year, how many times have you missed school, work, or family events because of your symptoms or treatment?

## What academic accommodations have been helpful to you in the past?

# HANDLING CRISIS

## Do you experience crisis episodes, including panic/anxiety attacks or psychosis?

### How do you recognize when you are in crisis/ need emergency or urgent care? What thoughts or behaviors are clues?

### During crises, do you typically seek out services yourself or do others recommend additional services?

## Do you currently have or previously used a safety plan to help you manage your symptoms? (Safety plans are a commonly used tool, particularly for individuals experiencing suicidal ideation.)

## Have you ever encountered legal or disciplinary issues as a result of your disability?

### What sanctions or legal consequences, if any, were imposed?

## Do you currently have or previously used a behavioral contract to help you manage your behaviors? (Behavioral contracts are often used to manage disruptive or inappropriate behaviors.)

# FURTHER INFORMATION

## Have you ever had thoughts of harming yourself or someone else? Is yes, is this current or how long ago was the last time you had these thoughts?

### Have ever made an attempt before? If so when did this happen?

## Do you self-injure, or have you self-injured in the past? If yes, is this happening currently or how long ago did you self-injure?

## Have you ever been diagnosed with an eating disorder? If yes, when did you have or do you currently have an eating disorder?

## Have you ever experienced hallucinations or delusions?

# TRAVEL

## How do you typically approach speaking in public or new situations or people?

## What sources of information have you used to learn about mental health services and cultural attitudes in the host country?

## Do you have comments, concerns or questions about your travel? Please explain.

**This form was produced by Mobility International USA,** [**http://www.miusa.org**](http://www.miusa.org) **with thanks to Shanti Ramcharan who is a Liscensed Professional Counselor and former Director of Disability Services at Emporia State University.**