MSF Project: _____

2025 MHPSS – Counseling Base Line Consultation Form

File information

Patient Code:	**Clinician Code** :	**Opening date** *(d/m/y):* / /
☐ New Admission ☐ Readmission	If readmission, the previous code was:	
Type of Intervention ☐ Psychotherapy/psychological support ☐ Counseling	**Type of Consultation:** ☐ Individual ☐ Couple ☐ Family (# of patients: ___) ☐ Group	
Checklist Reminder: ☐ Explain confidentiality ☐ Explain services/therapy ☐ Explain the therapist's/patient's roles ☐ Obtain informed consent	**Location of Intervention** ☐ Health Facility_____ ☐ MSF Health Facility_____ ☐ Mobile Clinic_____ ☐ Home Visit ☐ School Visit ☐ Remote/Phone ☐ Other_____	Permission to be contacted in case of need: ☐ By Phone ☐ F2F ☐ No permission

Demographics

Current Age:	**Sex/Gender:** ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Gender variant ☐ Prefer not to answer ☐ Unknown	**Current status:** ☐ Internally Displaced (IDP) ☐ Internationally displaced ☐ Returnee / repatriate ☐ Non-displaced / Resident ☐ Unknown	**Legal status:** ☐ Refugee ☐ Asylum seeker ☐ No status ☐ Unknown / Nationality:
Marital Status: ☐ Single ☐ Married/Cohabitation ☐ Divorced/Separated ☐ Widowed ☐ Partner left/missing	How many children does the patient have: How many people live with the patient have:	**Occupational status:** ☐ Permanent employee ☐ Occasional employee ☐ Unemployed ☐ Housework ☐ Non-applicable	**Education:** ☐ Illiterate ☐ Primary ☐ Secondary ☐ College ☐ University
Family tree:			

Knowledge of the service	☐ 1. Psychoeducation/Health Promotion	☐ 2. Leaflet	☐ 3. Radio/TV/Social media	☐ 4. Comments by others (e.g., friends) ☐ 5. Didn't know the service before
Main referral source	☐ 1. MSF	☐ 2. MoH	☐ 3. NGO	☐ 4. Other
Specific referral source	☐ IPD ☐ Emergency department ☐ Primary Health Center ☐ Health Promotion/CHW ☐ Other health professional ☐ Social Worker	☐ SRH ☐ NUT (ITFC, ATFC, etc.) ☐ Counselor ☐ Psychologist ☐ Psychiatrist/mhGAP ☐ International/Local NGO	☐ Self-referred ☐ Family member/friend ☐ Non-Health Authorities *(community leaders/representatives, prosecutor, etc)* ☐ School, mosque, church, etc. ☐ Other:	

Motive for Consultation

Why is the patient coming to you? *(Write using the patient's words)*

Current MH Status

What are the current symptoms / overall MH condition? *(Write using your own clinical assessment)*

Relevant details of the risk factors linked to the motive consultation / current MH status:

History of Mental Disorder	Risk Factors **Consider referral to mhGAP/psychologist*	
What was the diagnosis? Was the patient prescribed psychotropic medication? ☐ Never ☐ Previously ☐ Yes, currently. If yes, what medication/dosage:	Does the patient have a current suicidal risk? (if in doubt: ask the patient: "*Do you think about killing yourself?*" If "no" then mark "no risk"	☐ Yes ☐ No
	Does the patient present a risk of harming others?	☐ Yes ☐ No

Resilience & Coping

Coping strategies already used by the patient to address the main problem(s)/complaint(s):

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Current Symptoms or Complaints	***See Table 1***
Prioritize the three **symptoms** with their corresponding **codes**: 1_____ **(code:_____)** 2_____ **(code:_____)** 3_____ **(code:_____)** ***If current suicidal thoughts, suicide attempt, or psychotic symptoms consider referral to psychologist/mhGAP clinician**	
Main Syndrome: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8	
Duration of the main symptom: ☐ 1-7 days ☐ 1-4 weeks ☐ 1-3 months ☐ 4-12 months ☐ >1 year	

Baseline Scores	**MHOS:**	**PHQ9:** **GAD7:**	**CGI-S:** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 0=Not assessed; 1 = Normal/not ill; 2 = Suspected mentally ill; 3 = Mildly ill; 4 = Moderately ill; 5 = Markedly ill; 6 = Severely ill; 7 = Among the most extremely ill patients. **If the patient's score is ≥ 5, consider referral to mhGAP clinician/psychiatrist**

Clinical Diagnosis (Only by a psychologist, psychiatrist, or mhGAP clinician)	**Date of the main diagnosis:**	***See Table 2***
Main Diagnosis: _____(code: _____)	**Concomitant diagnosis** *(if applicable)*: _____(code: _____)	

Past / Precipitating Events *(possible reasons or causes linked to current problem)*					***See Table 3***
Prioritize the three **precipitant events** with their corresponding **codes**: 1_____ **(code:_____)** 2_____ **(code:_____)** 3_____ **(code:_____)**					
Main category of precipitant event	☐ 1. Medical condition	☐ 2. Violence	☐ 3. Separation or loss	☐ 4. Disaster	☐ 5. Other
Time from the main event: ☐ 1-3 days ☐ 4-7 days ☐ 1-4 weeks ☐ 1-3 months ☐ 4-12 months ☐ >1 year					
Relevant details of the past / precipitating events:					

Clinical Summary	**What is <u>your</u> explanation of the current state of problems** *(case formulation)*:

Intervention	**Goals for Therapy** (What are the agreed-upon treatment goals? Define these SMART goals together with the patient): 1. 2. 3.	
	Interventions/Techniques Used (What did you do in today's session?): 1. 2. 3.	**Homework** (What will the patient do before the next session?)

Follow-up & Referral	**Follow-up required** ☐ Yes ☐ No *(If no, use a closure form)*		**Next Session Date** *(d/m/y)*: ____ / ____ / _____
	Referral: ☐ Yes ☐ No		**Reason for referral:**
	1. ☐ Medical care (MSF, MoH, NGO)	5. ☐ Legal services	
	2. ☐ MSF psychiatric care	6. ☐ Protection services	
	3. ☐ Non-MSF psychiatric care	7. ☐ Hospitalization	
	4. ☐ Social services	8. ☐ Group support	
		9. ☐ Other:	