

Guidance for Psychological or Psychiatric Reports

The European Regulations and UK CAA's Guidance Material for fitness decision, acceptable treatments and required investigations (if specified) can be found in the medical section of the CAA website (www.caa.co.uk/medical). For many conditions, there are also flow charts available for guidance on the assessment process.

The following subheadings are for guidance purposes only and should not be taken as an exhaustive list.

1. Diagnoses

2. History of Complaint

- Presenting symptoms (incl reason for referral)
- Nature of condition, circumstances surrounding onset, precipitating factors
- Other relevant medical history

3. Nature Severity and Course of Illness

- Current symptoms
 - Specifically include details of any sleep deprivation, suicidal ideation, deliberate self-harm or delusions
- Results of clinical questionnaires e.g. Hamilton Scale Assessment

4. Treatment

- Received to date (e.g. CBT/counselling – past and ongoing treatment should be detailed)
- Current and past medications prescribed (incl start and finish dates)
- Details of any side effects from current medication
- Details of referral for further treatment to other healthcare professionals

5. Personal History

- Childhood/development
- Social history
 - Relationships
 - Smoking/Alcohol/other drugs
- Financial/forensic history

6. Previous Medical History/Family history

7. Follow Up Anticipated

- Anticipated follow up/frequency of clinical reviews and investigations

8. Likelihood of Recurrence

- Prognosis and risk of recurrence

9. Clinical Implications

- Any concerns regarding symptom and diagnosis progression, treatment compliance or risk of incapacity.