

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ MR: \_\_\_\_\_

## PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered  
by any of the following problems?

(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_

=Total Score: \_\_\_\_\_

If you checked off any problems, how difficult have these problems made it for you to do your  
work, take care of things at home, or get along with other people?

Not difficult at all <input type="checkbox"/>	Somewhat difficult <input type="checkbox"/>	Very difficult <input type="checkbox"/>	Extremely difficult <input type="checkbox"/>
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Therapist: \_\_\_\_\_ Therapist Signature: \_\_\_\_\_

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Name: \_\_\_\_\_ MR: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## GAD-7

Over the **last 2 weeks**, how often have you been bothered by the following problems?

(Use "✓" to indicate your answer)

Not  
at all

Several  
days

More than  
half the  
days

Nearly  
every day

1. Feeling nervous, anxious or on edge

0

1

2

3

2. Not being able to stop or control worrying

0

1

2

3

3. Worrying too much about different things

0

1

2

3

4. Trouble relaxing

0

1

2

3

5. Being so restless that it is hard to sit still

0

1

2

3

6. Becoming easily annoyed or irritable

0

1

2

3

7. Feeling afraid as if something awful might happen

0

1

2

3

(For office coding: Total Score T \_\_\_\_ = \_\_\_\_ + \_\_\_\_ + \_\_\_\_)

Severity Range:

\_\_\_ 0-4: Minimum

\_\_\_ 5-9: Mild

\_\_\_ 10-14: Moderate

\_\_\_ 15-21: Severe

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Name: \_\_\_\_\_ MR: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### CIDI Based Bipolar Disorder Screening Scale

	YES	NO
<p><i>Euphoria Stem Question:</i></p> <p>1. Some people have periods lasting several days when they feel much more excited and full of energy than usual. Their minds go too fast. They talk a lot. They are very restless or unable to sit still and they sometimes do things that are unusual for them, such as driving too fast or spending too much money. Have you ever had a period like this lasting several days or longer?</p> <p><i>If the answer is YES, skip to Criterion B screening question (3). If the answer is NO, answer the Irritability Stem Question next.</i></p>		
<p><i>Irritability Stem Question:</i></p> <p>2. Have you ever had a period lasting several days or longer when most of the time you were so irritable or grouchy that you either started arguments, shouted at people or hit people?</p> <p><i>If the answer is YES, continue to Criterion B screening question (3). If the answer is NO, don't answer any more questions.</i></p>		
<p><i>Criterion B Screening Question:</i></p> <p>3. People who have episodes like this often have changes in their thinking and behavior at the same time, like being more talkative, needing very little sleep, being very restless, going on buying sprees, and behaving in many ways they would normally think inappropriate. Did you ever have any of these changes during your episodes of being excited and full of energy or very irritable or grouchy?</p> <p><i>If the answer is YES, continue to answer the rest of the questions in this form. If the answer is NO, don't answer any more questions.</i></p>		
<p><i>Criterion B Symptom Questions:</i></p> <p>Think of an episode when you had the largest number of changes like these at the same time. During that episode, which of the following changes did you experience?</p>		
<p>1. Were you so irritable that you either started arguments, shouted at people or hit people?</p> <p><i>This first symptom question should be answered only if the euphoria stem question #1 was answered YES.</i></p>		
2. Did you become so restless or fidgety that you paced up and down or couldn't stand still?		
3. Did you do anything else that wasn't usual for you – like talking about things you would normally keep private, or acting in ways that you would usually find embarrassing?		
4. Did you try to do things that were impossible to do, like taking on large amounts of work?		
5. Did you constantly keep changing your plans or activities?		
6. Did you find it hard to keep your mind on what you were doing?		
7. Did your thoughts seem to jump from one thing to another or race through your head so fast you couldn't keep track of them?		
8. Did you sleep far less than usual and still not get tired or sleepy?		
9. Did you spend so much more money than usual that it caused you to have financial trouble?		

Patient Signature: \_\_\_\_\_ Clinician Signature: \_\_\_\_\_



**COLUMBIA-SUICIDE SEVERITY RATING SCALE**  
**Screeners/Recent – Self-Report**

Name: _____ MR: _____ Date: ____/____/____		<b>In The Past Month</b>	
Answer Questions 1 and 2		<b>YES</b>	<b>NO</b>
1) <i>Have you wished you were dead or wished you could go to sleep and not wake up?</i>			
2) <i>Have you actually had any thoughts about killing yourself?</i>			
If <b>YES</b> to 2, answer questions 3, 4, 5, and 6. If <b>NO</b> to 2, go directly to question 6			
3) <i>Have you thought about how you might do this?</i>			
4) <i>Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?</i>			
5) <i>Have you started to work out or worked out the details of how to kill yourself?</i> <i>Do you intend to carry out this plan?</i>			
		<b>In the Past 3 Months</b>	
6) <i>Have you done anything, started to do anything, or prepared to do anything to end your life?</i>  Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.			
<i>In your entire lifetime, how many times have you done any of these things?</i>			

Therapist Name: \_\_\_\_\_ Therapist Signature: \_\_\_\_\_

Name: \_\_\_\_\_ MR: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PCL-5**  
**Post-Traumatic Stress Disorder Checklist for DSM5**

**Instructions:** Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4



# PCL 5 - SCORING SUMMARY SHEET

NAME: \_\_\_\_\_

DATE COMPLETED: \_\_\_\_\_

*To Be Completed by Psychiatrist*

CRITERION	QUESTION NUMBER						TOTALS	
<b>INTRUSION SYMPTOMS</b>  <b>B</b>	<b>B1 (1)</b>	<b>B2 (2)</b>	<b>B3 (3)</b>	<b>B4 (4)</b>	<b>B5 (5)</b>			
<b>AVOIDANCE SYMPTOMS</b>  <b>C</b>	<b>C1 (6)</b>			<b>C2 (7)</b>				
<b>COGNITION &amp; MOOD CHANGE</b>  <b>D</b>	<b>D1 (8)</b>	<b>D2 (9)</b>	<b>D3 (10)</b>	<b>D4 (11)</b>	<b>D5 (12)</b>	<b>D6 (13)</b>	<b>D7 (14)</b>	
<b>AROUSAL &amp; REACTIVITY</b>  <b>E</b>	<b>E1 (15)</b>	<b>E2 (16)</b>	<b>E3 (17)</b>	<b>E4 (18)</b>	<b>E5 (19)</b>	<b>E6 (20)</b>		
						<b>TOTAL SCORE</b>		

Criterion B – at least one  $\geq 2$     YES/NO  
 Criterion C – at least one  $\geq 2$     YES/NO  
 Criterion D – at least two  $\geq 2$     YES/NO  
 Criterion E – at least two  $\geq 2$     YES/NO

DSM5 CATEGORIES	
Mild	0-20
Moderate	20-40
Severe	40-60
Extreme	60-80

Name: \_\_\_\_\_ MR: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### **Alcohol Use Disorders Identification Test – AUDIT**

*Please select the answer that is most correct for you to each of the following questions.*

1) How often do you have a drink containing alcohol? *(If you answer never, jump to questions 9&10)*

(0) Never (1) Monthly or less (2) 2-4 times a month (3) 2-3 times per week (4) 4 or more times a week

2) How many drinks containing alcohol do you have on a typical day when you are drinking?

(0) 1-2 (1) 3-4 (2) 5-6 (3) 7-8 (4) 10 or more

3) How often do you have six or more drinks on one occasion?

(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

4) How often during the last year have you found that you were not able to stop drinking once you had started?

(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

5) How often during the last year have you failed to do what was normally expected from you because of drinking?

(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

6) How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

7) How often during the last year have you had a feeling of guilt or remorse after drinking?

(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

8) How often during the last year have you been unable to remember what happened the night before because you had been drinking?

(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

9) Have you or someone else been injured as a result of your drinking?

(0) No (2) Yes, but not in the last year (3) Yes, during the last year

10) Has a relative or friend, or a doctor or other health worker, been concerned about your drinking or suggested you cut down?

(0) No (2) Yes, but not in the last year (3) Yes, during the last year

Total Score: \_\_\_\_\_

Therapist: \_\_\_\_\_ Therapist Signature: \_\_\_\_\_



MR: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Drug Abuse Screening Test—DAST-10**

These Questions Refer to the Past 12 Months

1	Have you used drugs other than those required for medical reasons?	Yes	No
2	Do you abuse more than one drug at a time?	Yes	No
3	Are you unable to stop using drugs when you want to?	Yes	No
4	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5	Do you ever feel bad or guilty about your drug use?	Yes	No
6	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7	Have you neglected your family because of your use of drugs?	Yes	No
8	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10	Have you had medical problems as a result of your drug use (eg, memory loss, hepatitis, convulsions, bleeding)?	Yes	No

Total Score: \_\_\_\_\_

**Guidelines for Interpretation of DAST-10**

Interpretation (Each "Yes" response = 1)

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	Encouragement and education
1-2	Low level	Risky behavior – feedback and advice
3-5	Moderate level	Harmful behavior – feedback and counseling; possible referral for specialized assessment
6-8	Substantial level	Intensive assessment and referral

Skinner HA. The Drug Abuse Screening Test. *Addictive Behavior*. 1982;7(4):363-371.

Yudko E, Lozhkina O, Fouts A. A comprehensive review of the psychometric properties of the Drug Abuse Screening Test.

*J Subst Abuse Treatment* 2007;32:189-198

Therapist: \_\_\_\_\_ Therapist Signature: \_\_\_\_\_



Name: \_\_\_\_\_ MR: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### **Rosenberg's Self-Esteem Scale** (Rosenberg, 1965)

**Instructions:** Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

	<b>Strongly Agree</b>	<b>Agree</b>	<b>Disagree</b>	<b>Strongly Disagree</b>
1. I feel that I'm a person of worth, at least on an equal plane with others.				
2. I feel that I have a number of good qualities.				
3. All in all, I am inclined to feel that I am a failure.				
4. I am able to do things as well as most other people.				
5. I feel I do not have much to be proud of.				
6. I take a positive attitude toward myself.				
7. On the whole, I am satisfied with myself.				
8. I wish I could have more respect for myself.				
9. I certainly feel useless at times.				
10. At times I think I am no good at all.				

Total Score: \_\_\_\_\_

**Scoring:** To score the items, assign a value to each of the 10 items as follows:

- **For items 1, 2, 4, 6, 7:** Strongly Agree=3, Agree=2, Disagree=1, and Strongly Disagree=0.
- **For items 3, 5, 8, 9, 10** (which are reversed in valence, and noted with the asterisks\*\* below): Strongly Agree=0, Agree=1, Disagree=2, and Strongly Disagree=3.

The scale ranges from 0-30, with 30 indicating the highest score possible. Higher scores indicate higher self-esteem. Scores below 15 indicate low self-esteem.

Therapist: \_\_\_\_\_ Therapist Signature: \_\_\_\_\_

Name: \_\_\_\_\_ MR: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### Satisfaction With Life Scale (SWLS)

Instructions: Below are five statements that you may agree or disagree with. Using the 1 - 7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding.

7 - Strongly agree

6 - Agree

5 - Slightly agree

4 - Neither agree nor disagree

3 - Slightly disagree

2 - Disagree

1 - Strongly disagree

\_\_\_\_\_ In most ways my life is close to my ideal.

\_\_\_\_\_ The conditions of my life are excellent.

\_\_\_\_\_ I am satisfied with my life.

\_\_\_\_\_ So far I have gotten the important things I want in life.

\_\_\_\_\_ If I could live my life over, I would change almost nothing.

Total Score: \_\_\_\_\_

Severity Range:

31 – 35: Extremely satisfied

26 – 30: Satisfied

21 – 25: Slightly satisfied

20: Neutral

15 – 19: Slightly dissatisfied

10 – 14: Dissatisfied

5 - 9: Extremely dissatisfied

Ed Diener, Robert A. Emmons, Randy J. Larsen and Sharon Griffin as noted in the 1985 article in the *Journal of Personality Assessment*.

Therapist: \_\_\_\_\_ Therapist Signature: \_\_\_\_\_



MR: \_\_\_\_\_

**WHODAS 2.0**  
**World Health Organization Disability Assessment Schedule 2.0**  
 36-item version, self-administered

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: ☐ Male ☐ Female Date: \_\_\_\_\_

This questionnaire asks about difficulties due to health/mental health conditions. Health conditions include **diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs**. Think back over the **past 30 days** and answer these questions thinking about how much difficulty you had doing the following activities. For each question, please circle only **one** response.

Numeric scores assigned to each of the items:						Clinician Use Only								
						1	2	3	4	5	Raw Item Score	Raw Domain Score	Average Domain Score	
In the <u>last 30 days</u> , how much difficulty did you have in:														
<b>Understanding and communicating</b>														
D1.1	<u>Concentrating</u> on doing something for <u>ten minutes</u> ?					None	Mild	Moderate	Severe	Extreme or cannot do		30	5	
D1.2	<u>Remembering</u> to do <u>important things</u> ?					None	Mild	Moderate	Severe	Extreme or cannot do				
D1.3	<u>Analyzing and finding solutions to problems</u> in day-to-day life?					None	Mild	Moderate	Severe	Extreme or cannot do				
D1.4	<u>Learning a new task</u> , for example, learning how to get to a new place?					None	Mild	Moderate	Severe	Extreme or cannot do				
D1.5	<u>Generally understanding</u> what people say?					None	Mild	Moderate	Severe	Extreme or cannot do				
D1.6	<u>Starting and maintaining a conversation</u> ?					None	Mild	Moderate	Severe	Extreme or cannot do				
<b>Getting around</b>														
D2.1	<u>Standing for long periods</u> , such as <u>30 minutes</u> ?					None	Mild	Moderate	Severe	Extreme or cannot do		25	5	
D2.2	<u>Standing up</u> from sitting down?					None	Mild	Moderate	Severe	Extreme or cannot do				
D2.3	<u>Moving around inside your home</u> ?					None	Mild	Moderate	Severe	Extreme or cannot do				
D2.4	<u>Getting out of your home</u> ?					None	Mild	Moderate	Severe	Extreme or cannot do				
D2.5	<u>Walking a long distance</u> , such as a kilometer (or equivalent)?					None	Mild	Moderate	Severe	Extreme or cannot do				
<b>Self-care</b>														
D3.1	<u>Washing your whole body</u> ?					None	Mild	Moderate	Severe	Extreme or cannot do		20	5	
D3.2	<u>Getting dressed</u> ?					None	Mild	Moderate	Severe	Extreme or cannot do				
D3.3	<u>Eating</u> ?					None	Mild	Moderate	Severe	Extreme or cannot do				
D3.4	<u>Staying by yourself for a few days</u> ?					None	Mild	Moderate	Severe	Extreme or cannot do				
<b>Getting along with people</b>														
D4.1	<u>Dealing</u> with people <u>you do not know</u> ?					None	Mild	Moderate	Severe	Extreme or cannot do		25	5	
D4.2	<u>Maintaining a friendship</u> ?					None	Mild	Moderate	Severe	Extreme or cannot do				
D4.3	<u>Getting along</u> with people who are <u>close</u> to you?					None	Mild	Moderate	Severe	Extreme or cannot do				
D4.4	<u>Making new friends</u> ?					None	Mild	Moderate	Severe	Extreme or cannot do				
D4.5	<u>Sexual</u> activities?					None	Mild	Moderate	Severe	Extreme or cannot do				

Therapist: \_\_\_\_\_ Therapist Signature: \_\_\_\_\_



Numeric scores assigned to each of the items:							Clinician Use Only								
							1	2	3	4	5	Raw Item Score	Raw Domain Score	Average Domain Score	
In the <u>last 30 days</u> , how much difficulty did you have in:															
<b>Life activities—Household</b>															
D5.1	Taking care of your <u>household responsibilities</u> ?						None	Mild	Moderate	Severe	Extreme or cannot do		20	5	
D5.2	Doing most important household tasks <u>well</u> ?						None	Mild	Moderate	Severe	Extreme or cannot do				
D5.3	Getting all of the household work <u>done</u> that you needed to do?						None	Mild	Moderate	Severe	Extreme or cannot do				
D5.4	Getting your household work done as <u>quickly</u> as needed?						None	Mild	Moderate	Severe	Extreme or cannot do				
<b>Life activities—School/Work</b>															
If you work (paid, non-paid, self-employed) or go to school, complete questions D5.5–D5.8, below. Otherwise, skip to D6.1.															
Because of your health condition, in the past <u>30 days</u> , how much difficulty did you have in:															
D5.5	Your day-to-day <u>work/school</u> ?						None	Mild	Moderate	Severe	Extreme or cannot do		20	5	
D5.6	Doing your most important work/school tasks <u>well</u> ?						None	Mild	Moderate	Severe	Extreme or cannot do				
D5.7	Getting all of the work <u>done</u> that you need to do?						None	Mild	Moderate	Severe	Extreme or cannot do				
D5.8	Getting your work done as <u>quickly</u> as needed?						None	Mild	Moderate	Severe	Extreme or cannot do				
<b>Participation in society</b>															
In the past <u>30 days</u> :															
D6.1	How much of a problem did you have in <u>joining in community activities</u> (for example, festivities, religious, or other activities) in the same way as anyone else can?						None	Mild	Moderate	Severe	Extreme or cannot do		40	5	
D6.2	How much of a problem did you have because of <u>barriers or hindrances</u> around you?						None	Mild	Moderate	Severe	Extreme or cannot do				
D6.3	How much of a problem did you have <u>living with dignity</u> because of the attitudes and actions of others?						None	Mild	Moderate	Severe	Extreme or cannot do				
D6.4	How much <u>time</u> did <u>you</u> spend on your health condition or its consequences?						None	Some	Moderate	A Lot	Extreme or cannot do				
D6.5	How much have <u>you</u> been <u>emotionally affected</u> by your health condition?						None	Mild	Moderate	Severe	Extreme or cannot do				
D6.6	How much has your health been a <u>drain on the financial resources</u> of you or your family?						None	Mild	Moderate	Severe	Extreme or cannot do				
D6.7	How much of a problem did your <u>family</u> have because of your health problems?						None	Mild	Moderate	Severe	Extreme or cannot do				
D6.8	How much of a problem did you have in doing things <u>by yourself</u> for <u>relaxation or pleasure</u> ?						None	Mild	Moderate	Severe	Extreme or cannot do				
General Disability Score (Total):											180	5			

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