Return from Approved Absence, Leave of Absence or Withdrawal Form

(please write very legibly)

Date:

Patient's Name: DOB:

Physician or Mental Health Professional Providing This Report:

Name and Degree:

MD (primary care provider) MD (psychiatrist)Psychologist,

Social WorkerCounselor Other:

Business Address:

Phone:

Fax #:

Treatment Information:

Date of patient's initial appointment with you:

Date of patient's last appointment with you:

Number of times patient was seen by you since medical withdrawal:

Total number of times patient was seen by you (if different than above):

Treatment modalities used: psychotherapy pharmacotherapy  both

Patient's symptom picture at time of first appointment with you following his/her medical withdrawal:

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Specific prescribed medications and dosages:

Will patient be continuing with medication tx after reenrollment? Yes No

Issues addressed in treatment with you:

Your diagnosis of patient (DSM- IV):

Axis I: 1)



3)

2) 4)



Axis Il:

Axis 111:



Observed changes in patients functioning during time in treatment with you:

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Remaining functional difficulties which need to be addressed in continued treatment or which may pose difficulties in relation to student's reenrollment:

Check any that may apply:

Attention]Concentration Impairment

Bipolar Mood Instability Eating Disorder

Homicidal Ideation/lntent

Interpersonal Difficulties (Axis Il related problems)

Motivational Difficulties

Neurovegetative Depressive Symptoms

 Obsessions/Compulsions

Panic Symptoms

Post Traumatic Stress Symptoms

Psychotic Symptoms

 Self-Destructive Behavior — Non-Suicidal (i.e. — cutting)

 Sleep Disturbance

 Social Phobia Symptoms

 Substance Abuse/Dependence

 Suicidal Ideation/lntent

\_\_\_\_\_\_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If any were selected above, please elaborate, particularly with regard to whether or not patient's remaining functional difficulties may contraindicate his/her return to the academic environment.

WA S H I N G T O N C O L L E G E

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If any functional difficulties were selected, please elaborate, particularly with regards to whether or not patient's functional difficulties may contraindicate his/her return to the residential community (living in a residence hall supervised by undergraduates) at Washington College. If any accommodation in the living environment is requested, please be specific.

Your recommendation regarding patient's readiness to return to academic enrollment:

Pt is ready to resume full-time academic reenrollment

Pt is not ready to resume full-time enrollment, but it is recommended that he/she enroll part-time

Pt is not yet ready to resume any academic enrollment.

Comments:

Recommended treatment plan if pt returns to Washington College enrollment:

Continued treatment is not necessary at this time

Pt will remain in treatment with current provider(s)

Treatment should be transitioned to Washington College provider(s)

Additional treatment plan comments:



Signature of Provider Date