WASHINGTON COLLEGE

Physician or Mental Health Professional's Assessment and Recommendation Regarding Patient's Readiness for Return from Medical Leave

(Please write very legibly or type)

Date: _____

Patient's Name: _____ DOB: _____

Physician or Mental Health Professional Providing This Report:

Name and Degree: _____

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

_____ Social Worker _____ Counselor _____ 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 leave: _____

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

Treatment modalities used: _____ psychotherapy _____ pharmacotherapy
_____surgery _____physical therapy _____other

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

_____

_____

_____

_____

_____

_____

Specific prescribed medications and dosages: _____

_____

_____

Will patient be continuing with medication treatment after re-enrollment? _____Yes _____ No

Issues addressed in treatment with you: _____

_____

_____

_____

_____

_____

_____

_____

_____

Medical Diagnosis _____

Psychiatric Diagnosis (DSM- IV):

Axis I: 1)_____ 3)_____

2) _____ 4) _____

Axis II: _____

Axis III: _____

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

_____

_____

_____

_____

_____

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

Check any that may apply:

_____ Attention/Concentration Impairment

_____Bipolar Mood Instability

_____Communicable Disease Diagnosis

_____ Eating Disorder

_____ Homicidal Ideation/Intent

_____Immuno-compromised State

_____ Interpersonal Difficulties (Axis II related problems)

_____ Motivational Difficulties

_____ Neuro-vegetative Depressive Symptoms

_____ Obsessions/Compulsions

_____Pain

_____ Panic Symptoms

_____Physical Impairment (Examples: Needs assistive devices such as a wheelchair, no athletics, etc.)

_____ Post Traumatic Stress Symptoms

_____Psychotic Symptoms

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

_____ Sleep Disturbance

_____ Social Phobia Symptoms

_____ Substance Abuse/Dependence

_____ Suicidal Ideation/Intent

_____ 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.

_____

_____

_____

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.

_____ Pt may return to full athletic participation (This needs to be checked if student wishes to participate)

Comments: _____

_____

_____

_____

_____

Recommended treatment plan if patient 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)

Please include a copy of your treatment plan. The more information you provide the better understanding we will have to assist this student.

Signature of Provider_____ **Date**_____