



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 leave:



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 _____

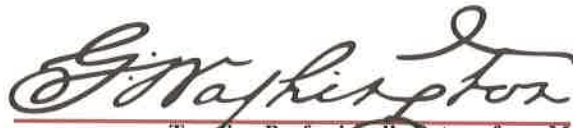
Psychiatric Diagnosis (DSM- IV):

Axis I: 1) _____ 3) _____
2) _____ 4) _____

Axis II: _____

Axis III: _____

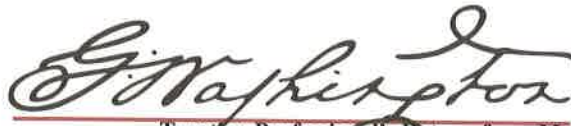
Observed changes in patients functioning during time in treatment with you:



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.

Three horizontal lines for text entry.

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.

Four horizontal lines for text entry.

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

- Four radio button options for academic readiness: full-time, part-time, not yet ready, and full athletic participation.

Comments section with four horizontal lines.

Recommended treatment plan if patient returns to Washington College enrollment:

- Three radio button options for treatment plan: not necessary, remain with current provider, or transition to Washington College provider.

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 _____