

Return from Medical Leave of Absence, Mental Health Care Provider Form

Instructions: This form is to be completed by the student's community mental health provider and be mailed to: Lauderdale Center for Student Health and Counseling, 1 College Circle, Geneseo NY, 14454

Student name: _____ D.O.B: _____

Provider name: _____ License #: _____

Provider licensed as: _____ State of licensure: _____

Dates of treatment (first session and most recent): _____

Treatment modalities (individual, group, IOP, inpatient, etc.): _____

Treatment program name (if applicable): _____

Initial DSM-V diagnoses: _____

Current DSM-V diagnoses: _____

Other relevant clinical issues:

Please provide your professional judgment in response to the following questions:

Has there been a substantial amelioration of the student's original medical/psychological condition?

If yes, please check all of the following that you have observed a marked reduction of in this student:

- _____ number of symptoms _____ functional impairment
- _____ severity of symptoms _____ subjective level of client distress
- _____ persistence of symptoms

If achieved, has the substantially improved condition been maintained stably for three consecutive months? _____yes _____no

Has there been a substantial reduction of any of the following safety related behaviors (mark N/A if not applicable)?

- Suicidal behaviors _____yes _____no
- Self-injury behaviors _____yes _____no
- Substance abuse behaviors _____yes _____no
- Failure to maintain ideal body weight for height _____yes _____no
- Food binging _____yes _____no
- Food purging or any other potentially harmful compensatory behaviors used for weight management (e.g., use of laxatives, excessive exercise, etc.) _____yes _____no
- Other: _____yes _____no

Please use the space below to let us know, in your professional judgement, given the academic rigor and social challenges associated with the college environment, if, in your professional judgement, this student is healthy enough continue pursuing their education, in this setting, at the current time. Please include any special considerations or treatment recommendations this student may benefit from once returning to campus:

Clinician signature: _____ Date: _____