Psychological Medical Withdrawal Re-Enrollment Provider Report

Part A – To Be Completed and Signed by Individual.

It is the applicant's responsibility to ensure the form is completed and received on time. This form should be completed no less than 30 days prior to the start of classes.

I___________________________________am requesting **readmission for**______________________________

Print name   term/year

My Medical Withdrawal was during the__________________ semester of________ . From_____________to_____________.

(Fall/Spring/Summer)   (YEAR)   (MM/YY)   (MM/YY)

I have supplied the provider with all information about my history of mental health, medical symptoms, and other related factors related to my ability to function as a student.

I voluntarily consent to the bidirectional release of information between the provider named below and the University of North Florida Dean of Students Office & Medical Withdrawal Committee (DOSMW). This release is for making decisions about my request for reenrollment and coordinating care, and includes the **entire medical record including all mental health records and records for alcohol and other drug treatment.** Paper or electronic copies of this authorization shall be sufficient authorization for the release of records. I release University of North Florida, the psychiatric/mental health provider treating me and their supervisor(s) from any liability arising from the release, miscommunication, or failure to release information, provided the release is done substantially in accordance with the law. The DOSMW makes no claims or guarantees about the handling of information by the parties above once released and agrees not to hold University of North Florida, DOSMW, or its staff liable for any consequences that result from such disclosure or non-disclosure. Individuals receiving the information may be governed by different or less strict laws/guidelines regarding the release of information than the counseling center staff. I understand that I may revoke these permissions at any time in writing, except to the extent that the providers have already acted in reliance on it. Absent such prior withdrawal this consent will expire in one year from last contact. Please speak with DOS staff and other relevant parties before signing if you have any questions. Reenrollment is not guaranteed. ***By signing this release form, I acknowledge that I have thoroughly read, understood and voluntarily granted all aforementioned permissions.***

Signature of Individual:____Date___________

PART B –Licensed Psychiatric/Mental Health Provider*| Please return by mail or fax. More info may be attached but* ***a letter will not substitute for legible completion of this form.***

Provider's Name**:**_________________________________Provider Phone: _________________________________

Provider Fax: _____________________________________

Licensed as_______________________________________License #____________________License State ___________

Patient's Name:____Patient Date of Birth________/_____/______

Number of sessions with client since the first day of their medical withdrawal: ___________

Date of Most Recent Session______/_____/_______

1) Current DSM Diagnoses/Concerns/Clinical Issues:____

____

____

2) Diagnoses/Concerns/Clinical Issues for which the individual is seeking, or initially sought, treatment:

____

____

____

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

Questions	Please check the appropriate answer
4) Currently, the symptoms related to Diagnosis above are enough to prevent individual from functioning effectively as a student.	☐ Yes ☐ No
5) Further treatment recommendations include (Medications, Counseling, Case Management, Follow up appointments with you, etc.):	☐ Psychotherapy: (1x/week_______, more than once a week_______, less than once a week________________) ☐ Partial Hospitalization/day treatment ☐ Inpatient including substance and ED recovery ☐ Other: ________________________________ ☐ None
6) Individual is willing, likely and has the resources to engage in such treatment voluntarily until complete.	☐ Yes ☐ No ☐ I Don't Know
7) During treatment he/she has missed one or more appointments or rescheduled against medical advice.	☐ Yes ☐ No

8) Is there current evidence or reports of the following behaviors? Please mark "never reported" if individual did not evidence OR disclose a history of such behaviors at any point during treatment.

Suicidal behaviors	☐ Yes	☐ Yes, but reduced	☐ No	☐ Not reported
Self-injury behaviors	☐ Yes	☐ Yes, but reduced	☐ No	☐ Not reported
Impulsivity or risky behaviors	☐ Yes	☐ Yes, but reduced	☐ No	☐ Not reported
Substance abuse behaviors	☐ Yes	☐ Yes, but reduced	☐ No	☐ Not reported
Failure to maintain weight at > 90% of Ideal Body Weight for height	☐ Yes	☐ Yes, but reduced	☐ No	☐ Not reported
Food binging, purging, other harmful behaviors for weight control	☐ Yes	☐ Yes, but reduced	☐ No	☐ Not reported
Thoughts, behaviors, psychosis or other related ideation related to harming others	☐ Yes	☐ Yes, but reduced	☐ No	☐ Not reported

9) There is evidence of substantial reduction in all above behaviors and post-treatment stability maintained consecutively for:	☐ 0-1 month ☐ 1-3 months ☐ More than 3 months ☐ 6+ months ☐ No safety concerns reported
10) Please check all the following that you have observed **a marked reduction** of in this individual during treatment, if applicable:	☐ Number of symptoms ☐ Severity/Persistence of symptoms ☐ Functional impairment ☐ Subjective distress
11) There has been enough significant improvement in the individual's original medical condition for you to believe this individual can function successfully as a student at this time.	☐ Yes ☐ No
12) The student is at minimal or no risk for harm to self or others if he/she were to return to a rigorous academic schedule.	☐ Yes ☐ No
13) Do you recommend any limitations for enrollment in courses or accommodations associated with this individual returning to school?	☐ No limitations (full course load) ☐ Limitations (reduced course load) ☐ Other/Accom: _________________

Clinician Signature____Date_____________________________

ONCE COMPLETED, PLEASE FAX THIS DOCUMENT TO (904) 620-3922