

Physician or Mental Health Professional's Assessment and Recommendation
Regarding Patient's Need for Academic Relief

Date: _____ Student ID#: _____

Patient's Name : _____ DOB: _____

Physician or Mental Health Professional Providing This Report:

Name and Degree: _____

_____ Physician _____ 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: _____

Total number of times patient was seen by you: _____

(Check all that apply)

Treatment modalities used: _____ psychotherapy _____ pharmacotherapy _____ other: specify _____

Description of symptoms at time of first appointment with you:

Prescribed medications and dosages: _____

Remaining functional difficulties which need to be addressed in continued treatment:

Check any that may apply:

- Anxiety Symptoms
- Attention / Concentration Impairment
- Bipolar Mood Instability
- Depressive Symptoms
- Eating Disorder
- Homicidal Ideation/Intent
- Interpersonal Difficulties
- Motivational Difficulties
- Obsessions/Compulsions
- Panic Symptoms
- Personality Disorder
- 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 student's remaining functional difficulties may contraindicate a return to the academic environment.

Explain how patient's symptoms may have affected academic functioning:

Signature of Provider

Date