**Physician or Mental Health Professional’s Assessment and Recommendation**

**Regarding Patient’s Readiness for Virginia Tech Reenrollment**

**(Please write very legibly)**

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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 withdrawal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

(Check all that apply)

Treatment modalities used: \_\_\_\_\_ psychotherapy \_\_\_\_\_ pharmacotherapy \_\_\_\_\_ other: specify\_\_\_\_\_\_\_\_\_\_\_\_

Description of symptoms at time of first appointment with you following their withdrawal:

Prescribed medications and dosages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Will patient be continuing with medication treatment after reenrollment? \_\_\_\_\_ Yes \_\_\_\_\_ No

Issues addressed in treatment with you:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your diagnosis of patient (DSM-5):**

**Observed changes in patient’s 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 reenrollment:**

**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

\_\_\_\_\_ Posttraumatic 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 difficulties were selected, please elaborate, particularly with regard to whether or not student’s remaining functional difficulties may contraindicate a return to the academic environment.

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**Your recommendation regarding patient’s readiness to return to academic enrollment:**

\_\_\_\_\_Student is ready to resume full-time academic reenrollment

\_\_\_\_\_Student is not ready to resume full-time enrollment, but it is recommended that they enroll part-time

\_\_\_\_\_Student is not yet ready to resume any academic enrollment.

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_

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**Recommended treatment plan if student returns to Virginia Tech enrollment:**

\_\_\_\_\_ Continued treatment is not necessary at this time

\_\_\_\_\_ Student will remain in treatment with current provider(s)

\_\_\_\_\_ Treatment should be transitioned to Virginia Tech or off-campus provider(s)

 Additional treatment plan comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Signature of Provider Date**