

Community Provider Report Form

Attention: Medical Leave of Absence Committee
Counseling and Psychiatric Service
Georgetown University
1 Darnall Hall
37th And O Streets, N.W.
Washington, D.C. 20057
(202) 687-6985 Fax 687-6158

NOTE: This form is to be completed by the student's community mental health clinician/service provider and mailed by the provider directly to the Medical Leave of Absence Committee at the address indicated above.

Clinician Name _____	Student Name _____
Licensed as _____	Date of First Session _____
License # _____	Date of Most Recent Session _____
State of Licensure _____	Total # of Treatment Sessions _____
Initial DSM Axis I Diagnosis _____	Initial DSM Axis II Diagnosis _____
Current DSM Axis I Diagnosis _____	Current DSM Axis II Diagnosis _____

GAF upon initial session (DSM Axis V) _____ GAF upon latest session (DSM Axis V) _____

Please provide your professional judgment in response to the following questions regarding the student named above.

Yes No 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
- Severity of symptoms
- Persistence of symptoms
- Functional impairment
- Subjective level of client distress

Yes No Once achieved, has the substantially improved condition been maintained stably for three consecutive months?

Has there been a substantial reduction of any of the following safety-related behaviors the student may have been engaging in?

- | | |
|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | Suicidal behaviors |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | Self-injury behaviors |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | Substance abuse behaviors |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | Failure to maintain weight at minimum of 90% of Ideal Body Weight for height |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | Food binging |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | Food purging or any other potentially harmful compensatory behaviors used for weight management (e.g., use of laxatives, excessive exercise, etc.) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | Other: _____ |

Yes No Once achieved, has the substantial reduction in safety related behaviors been maintained stably for three consecutive months?

Clinician Signature

Date

Clinician's address, telephone, email: _____

Please provide a brief narrative indicating the degree to which issues have been resolved, to make recommendations for continued care; to expand on your responses to the questions above; and to record any other comments or observations you wish to make regarding the student and the his or her ability to function safely, stably, and successfully as a full-time university student at this time.