

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 _____
Licensed as _____
License # _____
State of Licensure _____
Initial DSM Axis I Diagnosis _____
Current DSM Axis I Diagnosis _____

Student Name _____
Date of First Session _____
Date of Most Recent Session _____
Total # of Treatment Sessions _____
Initial DSM Axis II 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 the student’s mental health improved since taking a medical leave of absence?

_____ For how many months has the student exhibited stable and improved mental health?

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

___ Yes ___ No ___ N/A
___ Yes ___ No ___ N/A
___ Yes ___ No ___ N/A
___ Yes ___ No ___ N/A
___ Yes ___ No ___ N/A
___ Yes ___ No ___ N/A
___ Yes ___ No ___ N/A

Suicidal behaviors
Self-injury behaviors
Substance abuse behaviors
Failure to maintain weight at minimum of 90% of Ideal Body Weight for height
Food binging
Food purging or any other potentially harmful compensatory behaviors used for weight management (e.g., use of laxatives, excessive exercise, etc.)
Other: _____

_____ For how many months has the student exhibited substantial reduction in safety related behaviors?

Please provide a brief narrative describing the current status of the student’s mental health condition. Please indicate the degree to which the student’s health has improved, including whether there has been a decrease in the number, severity, or persistence of symptoms, functional impairment, and client distress. Please also include recommendations for continued care and provide any other comments or observations you wish to make regarding the student and his or her ability to function safely, stably, and successfully as a full-time university student at this time.

Clinician Signature

Date

Clinician’s address, telephone, email: _____