Community Provider Report Form
Andrews University
Counseling & Testing Center (CTC)
Bell Hall Suite 123
Berrien Springs, MI 49104
(269) 471-3470

Please Print:

Note: This form is to be completed by the student’s community mental health provider and mailed by the provider directly to CTC at the address indicated above. “Provider” means doctoral level Licensed Healthcare Provider (e.g., MD, DO, Psychologist, Licensed Clinical Social Worker, etc.). This original, signed licensed provider form must be received no later than 2 weeks prior to planned semester of return. Faxed or photocopied documents will not be accepted.

Clinician Name: ______________________ Degree: ___________________ Student Name: ______________________

Licensed as: ______________________ Date of First Session: ______________________
License #: ______________________ Date of Most Recent Session: ______________________
State of Licensure: ______________________ Total # of Treatment Sessions: ______________________
GAF Score at Start of Treatment: ______________________ GAF Score at End of Treatment: ______________________
Initial DSM Axis I Diagnosis: ______________________ Current DSM Axis I Diagnosis: ______________________

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 at least two consecutive months?

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 Suicidal behaviors
__ Yes __ No _N/A Self injurious behaviors
__ Yes __ No _N/A Substance abuse behaviors
__ Yes __ No _N/A Failure to maintain weight at minimum of 85% of Ideal Body Weight for height
__ Yes __ No _N/A Food Binging
__ Yes __ No _N/A Food purging or any other potentially harmful compensatory behaviors used for weight management (e.g., use of laxatives, excessive exercise, etc.)
__ Yes __ No _N/A Other: ______________________

Once achieved, has the substantial reduction in safety related behaviors been maintained stably for at least two consecutive months?

__________________________ ______________________
Clinician Signature Date

Please use the back of this page or attach additional documentation if you wish to expand on your responses to the questions above and/or to record any other comments or observations you may wish to make regarding the student and his or her readiness/ability to function safely, stably, and successfully as a full-time university student at this time.

Thank you

Updated 2-19-2010