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: _____
_ Yes _No _N/A 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