BARNARD COLLEGE

Health Evaluation form for Return after Medical and/or Mental Health Leave

To the Student: Please review this form with your current health care or mental health care provider. This form must be submitted to the Executive Director of Student Health and Wellness by June 1 for Fall return or November 1 for Spring return. In order to resume study at Barnard, you will be asked to demonstrate that the condition that has caused you to take a leave of absence has sufficiently resolved to allow resumption of studies. Please be aware that you will also need to schedule an assessment interview with either the Director of Primary Care Health Services or the Furman Counseling Center prior to the start of the semester in which you wish to return to campus.

To the Health Care Provider: The student named below is requesting to return to Barnard College after a leave. The information you provide will be used in helping to reach a decision regarding this request. **It is of vital importance that you indicate this student's readiness to resume academic study and/or residence on campus**. Please also be as detailed as possible about the course of treatment provided to this student during the period of the leave of absence. Upon completion, please fax this form with a copy of your release of information to:

Student Name:_____ **Date of Birth**:_____

Student ID #: _____ **Date**:_____

Diagnosis:_____ **Date of Diagnosis**:_____

Duration of treatment by this provider:_____

Current medical and/or psychological status (please be specific):

_____

_____

_____

Current symptoms which might interfere with academic performance (please be specific):

_____

_____

_____

Current and continuing treatment modalities (please check all that apply and give details about who will provide this recommended continuing care):

◯Medications: _____

◯Physical therapy:_____

◯Nutritional therapy:_____

◯Individual and/or group therapy:_____

◯In-patient treatment:_____

◯Other:_____

Comments:

Current medications:

Medication	Date Started	Dose	Frequency	Side Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Limitations of present condition to academic performance:

	Mild	Moderate	Severe	N/A	Comments:
Concentration	◯	◯	◯	◯	_____
Reading	◯	◯	◯	◯	_____
Writing	◯	◯	◯	◯	_____
Ability to attend class	◯	◯	◯	◯	_____
Other: _____	◯	◯	◯	◯	_____

Current Risk Assessment:

	None	Moderate	High	N/A	Unable to assess	Comments:
Risk of Medical Instability	◯	◯	◯	◯	◯	_____
Suicide risk	◯	◯	◯	◯	◯	_____
Violence Risk	◯	◯	◯	◯	◯	_____
Self-injury Risk	◯	◯	◯	◯	◯	_____

Previous treatment modalities (provide details for all that apply):

	Dates	**Location/Name of Institution**
◯Outpatient treatment	_____	_____
◯Partial hospitalization	_____	_____
◯Residential/inpatient treatment	_____	_____
◯Surgical procedures	_____	_____

What functional difficulties remain which may require on-going treatment or which may interfere with this student's ability to perform to her best abilities?

_____ Attention / Concentration Impairment
_____ Eating Disorder
_____ Homicidal Ideation/Intent
_____ Interpersonal Difficulties (Axis II related problems)
_____ Motivational Difficulties
_____ Mood Instability
_____ Neurovegetative Depressive Symptoms
_____ Obsessions/Compulsions
_____ Panic Symptoms
_____ Post Traumatic Stress Symptoms
_____ Psychotic Symptoms
_____ Relationship Violence
_____ Self-Injurious Behavior
_____ Sleep Disturbance
_____ Social Phobia Symptoms
_____ Substance Abuse/Dependence
_____ Other:

If any of the above were selected, please elaborate.

_____

_____

_____

_____

_____

_____

PROVIDER COMPLETING THIS FORM:

Please check one or both below:

◯ **I believe that this student is medically stable and is able to return to Barnard College as a full time student**.

◯ **I believe that this student is psychologically stable and is able to return to Barnard College as a full time student**.

Please check one below and complete appropriate section:

◯ **I have examined this student and have completed this form based upon my own personal assessment of the student's health status**:

Provider name:_____ Date:_____

Provider Practice name and address:

_____

Hospital Affiliation:_____

Provider signature:_____ License number:_____

Telephone number:_____ Fax Number:_____

◯ **I have not examined this student personally, but have based my assessment on a thorough review of the medical/psychological chart and/or consultation**:

Provider name:_____ Date:_____

Provider Practice name and address:

_____

Hospital Affiliation:_____

Provider signature:_____ License number:_____

Telephone number:_____ Fax Number:_____

If the student is receiving treatment from any other providers, please indicate:

Name of provider:_____ Telephone number:_____

PLEASE ATTACH ANY RELEVANT INFORMATION.