FORDHAM UNIVERSITY

Community Provider Form—Mental Health

Mental Health and Medical-Related Re-Entry Process

Rose Hill/Louis Calder Center: Office of Residential Life | p. 718.817.3080 | f. 718.817.5582 | reentryrh@fordham.edu

Lincoln Center/Westchester:Office of Dean of Students | p. 212.636.6250 | f. 212.636.7987 | deanofsalc@fordham.edu

To the student: This form is meant to ease the provision of information related to your request to resume classes and/or housing at Fordham University. Please complete the "Student Information" section, sign the release of information, and give the form to your provider. Please communicate to your provider the deadlines for completing and submitting this form. The form can be submitted by you or your provider.

To the evaluator: The student named below has requested to return to Fordham University following a leave, withdrawal or hospitalization. The information you provide will help us determine a plan of continued care if and when the student returns to classes and/or university housing. Please complete and return this form to the student or to the appropriate campus office, listed above. Missing information on this form may delay the students' re-entry process.

Student Information: Please fill this section out before you submit to your provider.

Student Name: ______________________________Date of Birth: ______________
FIDN: ____________ Campus: ____________ College: ____________ Class standing: ____________

I intend to make these living arrangements for my return (choose one:

❑ Commute to classes from home ❑ Commute to classes from local Fordham area ❑ University housing

Treatment Summary: To be completed by caregiver

Type of treatment provided (check all that apply):

❑ Medical treatment ❑ Individual Therapy ❑ Group Therapy ❑ Family Therapy ❑ Psychiatric Services
❑ Inpatient Psychiatric Treatment ❑ Nutritional Evaluation/Treatment ❑ Substance Abuse Treatment
❑ Other (please specify): ____

Summary Reason for Treatment: ____

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Date of First Session: ____________________ Date of Most Recent Session: ____________________
Number of Attended Sessions: ______________ DSM Diagnosis: ______________________________
Dates of hospitalization (if applicable): ________ to _________

Please describe the student's *current* treatment plan (including modality and frequency of sessions): ____________

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____

Please list any current medications:____

Have you observed a significant improvement in the student's condition since their departure from Fordham? __Yes__ No

Assessment:

How would you rate the student's level of functioning on the following (please circle):

Insight:	Good	Fair	Poor	Impulse Control:	Good	Fair	Poor
Judgment:	Good	Fair	Poor	Overall physical health	Good	Fair	Poor
Reality Testing:	Good	Fair	Poor	Independent physical function	Good	Fair	Poor
Attitude toward treatment:	Good	Fair	Poor				

Additional comments on items selected as Fair or Poor: ____

____

In the section below please endorse observed behaviors within the time frame specified (please do not leave blank):

Symptoms or Behaviors Observed:	Currently Observed	Within past 12 months	Prior to last 12 months	Never Observed
please elaborate where necessary				
Disruptive/ Reckless/ Deviant behaviors (*please circle*: destructive behavior, DUI, disorderly conduct, verbal aggression, violence, other:______________________________)				
Disordered eating behaviors (*please circle*: low body weight, purging, restricting, binging, laxative use, excessive exercising, other:______________________________)				
Homicidal thoughts				
Homicidal behaviors				
Medically decompensated/ Physical decline				
Poor self-care				
Psychotic Symptoms				
Substance use/abuse behaviors				
Self-injurious (not suicidal) behaviors				
Suicidal thoughts				
Suicidal behaviors				
Other:				
Other:				

1. Please describe the nature, duration, symptoms and severity in all areas of concern upon initial presentation and how they have been addressed and improved with treatment.

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2. Please describe medical/ psychological treatment and/or other measures that would promote the student's mental health and/or wellness upon their return to Fordham (please note treatment modality, frequency, theoretical approach to treatment if one is optimal, and name of treatment provider(s) if identified):

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3. What, if any, difficulties do you anticipate for the student upon return to classes? To on-campus housing (if applicable)? What circumstances do you believe might exacerbate the student's condition (i.e. triggers, relationships, environmental factors)?

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4. To what extent do you anticipate the student would be at risk for physical or mental relapse and/or decompensation if the recommended treatment plan is not followed?

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5. Please specify any ways in which the current treatment plan would change upon students return to Fordham University (and to on-campus housing, if applicable).

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Recommendations:

Based on your professional opinion of this student's prognosis, please check one of the following:

___ This student is able to function autonomously on campus (e.g.; if on medication, student can follow the treatment plan without monitoring, student requires no supervision to ensure their safety; student is able to seek help if needed). Therefore, the student is able to return to university on a full-time basis, and is appropriate for university housing.

___ This student is functioning well enough to return to the university on a full-time basis however supportive physical measures will be needed for the students' successful return to university housing. (Please explain below)

___ This student is functioning well enough to return to the university on a full-time basis however is ***not*** appropriate for university housing.

___ This student is functioning well enough to return to the university, but only on a part-time basis (or reduced course-load).

___ This student is ***not*** functioning well enough to return to the university at this time.

___ Other (please explain): ____

____

____

Please provide any other recommendations for the student's return to a university environment:

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As always, mental health professionals can make no guarantees or promises of success, but in the exercise of my best professional judgment, I make these recommendations for your consideration.

______________________________ ________ ______________________________

Clinicians' signature Date Current state and license number

____

Clinicians' printed name

Practice address: Practice Phone & Fax

______________________________ ______________________________

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