FORDHAM UNIVERSITY

Community Provider Form—Medical/Physical

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 ❑ Psychiatric Services ❑ Substance Abuse Treatment ❑ Partial Hospitalization

❑ Nutritional Evaluation/Treatment ❑ Pain Management ❑ Physical Therapy

❑ Surgery (type and Date):_____

❑ Hospitalization (please list dates and hospital name): _____

❑ Other (please specify): _____

Summary Reason for Treatment: _____

_____

_____

Date of start of treatment: _____ Date of most recent appointment: _____

Number of attended appointments: _____ DSM Diagnoses (if applicable): _____

Please describe the student's *current* treatment plan (including treatment follow-up frequency and specialty):

_____

_____

_____

Please list any current medications:_____

Have you observed a significant improvement in the student's health since their departure from Fordham? ☐ Yes ☐ No

Assessment:

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

Overall physical health	N/A	Good	Fair	Poor
Attitude toward treatment:	N/A	Good	Fair	Poor
Independent physical function	N/A	Good	Fair	Poor
Labs:	N/A	Normal	Abnormal -- Please list and explain any abnormalities:	

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:	Never observed	Within past 12 months	Currently observed
please elaborate where necessary			
Medically decompensated/ Physical decline			
Poor self-care			
Disordered eating behaviors (please circle: low body weight, purging, restricting, binging, laxative use, excessive exercising, other:_____)			
Disruptive/ Reckless/ Deviant behaviors (please circle: destructive behavior, DUI, disorderly conduct, verbal aggression, violence, other:_____)			
Psychological Symptoms (please elaborate:_____)			
Substance use/abuse behaviors			
Self-injurious behaviors (not suicidal)			

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.

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

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

4. To what extent do you anticipate the student would be at risk for physical decompensation should the student not participate in the recommended treatment plan?

_____

_____

_____

_____

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

_____

_____

_____

_____

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

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

☐ This student is ***not*** medically 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:

_____

_____

_____

As always, medical 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

_____ _____

_____ _____

_____ _____