

Community Provider Report Form

This form is to be completed by the student's community physical or mental health clinician/service provider and mailed by the provider directly to the Director of Counseling Services for psychological/psychiatric conditions or the Director of Student Health Services for medical conditions at the address indicated below.

Student Name: _____ Student #: _____

Clinician Name and Degree: _____

___ Psychologist ___ Counselor ___ Social Worker ___ Psychiatrist

___ Physician ___ Nurse Practitioner ___ Physician's Assistant

___ Other: _____

License Number: _____ State of Licensure: _____

Business Address: _____

Phone: _____ FAX: _____

Treatment and Student Status

Date of First Session: _____ Date of Last Session: _____

Total Number of Sessions: _____

Medical Diagnosis: _____

DSM Diagnosis: _____

Initial Treatment Recommendations: _____

YES NO Has the student complied with treatment recommendations?

Treatment Summary: _____

Medications and Dosages: _____

Please provide your professional judgment in response to the following questions regarding this student.

YES NO Has there been a substantial amelioration of the student's original 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 student distress

YES NO Once achieved, has the substantially improved condition been maintained stably for three 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 injury behaviors
YES	NO	N/A	Substance abuse behaviors
YES	NO	N/A	Failure to maintain weight at minimum of 90% 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 Once achieved, has the substantial reduction in safety related behaviors been maintained stably for three consecutive months?

Academic Enrollment Recommendations

___ Client is ready to return to the unstructured and demanding academic environment on a full-time basis.

___ Client is not ready to resume full-time enrollment, but it is recommended that he/she enroll part-time.

___ Client is not yet ready to resume any academic enrollment.

Comments: _____

Continued Treatment Recommendations

___ Continued treatment is **not** recommended at this time.

___ Client will remain in treatment with this provider.

___ Treatment should be transitioned to CCU Student Health Services or Counseling Services.

___ Treatment will be transitioned to another provider: _____

Additional treatment plan recommendations: _____

Signature of Provider

Date

Certification of Readiness to Return

I certify that the student is:

- medically or
- psychologically

able to return to Coastal Carolina University and to fulfill the fundamental responsibilities of academic and residential life.

Signature of Provider

Date

DO NOT RETURN THIS FORM TO THE STUDENT**For medical conditions, return form directly to:**

Director, Student Health Services FAX: (843) 349-6546
Coastal Carolina University
P.O. Box 261954
Conway, SC 29528-6054

For psychological/psychiatric conditions, return form directly to:

Director, Counseling Services FAX: (843) 349-2898
Coastal Carolina University
P.O. Box 261954
Conway, SC 29528-6054

Questions may be addressed to:

Director of Student Health Services (843) 349-6543
Director of Counseling Services (843) 349-2305