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 indicted 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