Cornell University

Cornell Health

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Health Leave of Absence: MENTAL HEALTH CARE PROVIDER REPORT

INSTRUCTIONS: This form is to be completed in full by the student's mental health clinician or other service provider.

Send ATTN: HLOA/HEALTH RECORDS by **FAX**: 607.255.0269 or by **MAIL**: use above address

- We are interested in obtaining information about your work with the student and the **progress** made.
- Given the rigor and challenges of the academic and social environment to which the student will return, we would like to know whether you feel the student is **healthy enough to continue pursuing education, in this setting, at the current time**.
- It is important that we have **as much information from you as is possible** so we can support the student's success upon return.

STUDENT NAME _____ **DATE OF BIRTH** _____

TREATMENT INFORMATION

Initial DSM-V diagnosis _____

Current DSM-V diagnosis _____

TREATMENT MODALITY (please check all that apply to *your* contacts with student)

☐ Individual therapy	☐ Individual nutrition counseling	☐ Partial hospitalization program
☐ Group therapy	☐ IOP	☐ Inpatient treatment
☐ Medication management	☐ Day treatment	☐ Substance abuse treatment program

DURATION OF TREATMENT

If individual or group:

Date of first visit *after leave began* _____

Date of most recent visit _____

Total number of visits _____

If a treatment program:

Name of program _____

Date of admission _____

Date of discharge _____

TERMINATION

Has the student terminated treatment with you or your program? ☐ Yes ☐ No

Was the termination mutual and planned?

☐ Yes **What was the discharge plan?** _____

☐ No **Please explain** _____

ASSESSMENT

- Indicate **level of functioning**: 1–10 (1=poor, 10=excellent) At start of treatment: _____ Most recently: _____
- Has there been a **substantial amelioration** of the student's original health/psychological condition? ☐ Yes ☐ No
  - **If yes**, check all of the following in which you have observed a marked reduction in this student:
    - ☐ Number of symptoms
    - ☐ Severity of symptoms
    - ☐ Persistence of symptoms
    - ☐ Functional impairment
    - ☐ Subjective level of distress
- Has there been a **substantial reduction** of any of the following behaviors the student may have been engaging in?

▪ Suicidal behaviors	☐ Yes	☐ No	☐ N/A
▪ Self-injury behaviors	☐ Yes	☐ No	☐ N/A
▪ Substance abuse behaviors	☐ Yes	☐ No	☐ N/A
▪ Failure to maintain 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 (use of laxatives, excessive exercise, etc.)	☐ Yes	☐ No	☐ N/A
▪ Other _____	☐ Yes	☐ No	☐ N/A

- Once achieved, has the substantial reduction been **maintained stably for 3 consecutive months?** ☐ Yes ☐ No
  - **If nutrition**, attach a brief statement about the student's nutrition status.

  Please use this space, if needed, to expand:

- Please use the space below to let us know if, in your professional judgment, given the rigor and challenges of the academic and social environment to which the student will return, s/he is **healthy enough to continue pursuing their education, in this setting, at the current time**. Include any special considerations the student may need upon return to campus.

CLINICIAN INFORMATION

Name _____ Signature _____

Date _____

Profession licensed as _____ License # and State _____