



CENTER FOR HEALTH AND COUNSELING SERVICES

505 Ramapo Valley Road, Mahwah, NJ 07430-1680

Counseling Services: Phone (201) 684-7522 Fax (201) 684-7995

Health Services: Phone (201) 684-7536 Fax (201) 684-7534

www.ramapo.edu/studentlife/healthcounseling

Community Provider Report Form

NOTE: This form is to be completed by the student's community mental health clinician or medical provider and mailed by the provider to the appropriate unit (Counseling or Health) within the Center for Health and Counseling Services.

This form must be received no later than August 1st for a planned fall semester return or December 1st for a planned spring semester return.

Please have student sign an authorization for you to release information to the Center for Health and Counseling Services.

Provider name _____
Licensed as _____
License # _____
State of Licensure _____
Initial Diagnosis _____
(DSM or ICD-9)
Current Diagnosis _____
(DSM or ICD-9)

Student name _____
Date of first session _____
Date of most recent session _____
Total # of Treatment Sessions _____
If mental health clinician include:
GAF score at start of treatment _____
Current GAF score: _____

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

Has there been a substantial amelioration of the student's original medical/psychological condition? ___ Yes ___ No

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 client distress

Once achieved, how long has the substantially improved condition been maintained stably?

Has there been a substantial reduction of any of the following safety related behaviors the student may have been engaging in?

- | | |
|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | Suicidal behaviors |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | Self injury behaviors |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | Substance abuse behaviors |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | Failure to maintain weight at minimum of 90% of Ideal Body Weight for height after being diagnosed and treated for an eating disorder |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | Food binging |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | Food purging or any other potentially harmful compensatory behaviors used for weight management (e.g., use of laxatives, excessive exercise, etc.) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | Blood sugar levels |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | Breakthrough seizures or sudden unconsciousness |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | Asthmatic events |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | Other: _____ |

Once achieved, how long has the substantial reduction in safety related behaviors been maintained stably? _____

Do you deem this student ready to resume academic studies at RCNJ? Yes No

Would you recommend any conditions or restrictions to returning to school (e.g., Part-time academic status, commuter status, etc). Yes No

If yes, please explain: _____

Provider Signature

Date

Please use the rest of this page or attach additional documentation if you wish to expand on your responses to the questions above and/or to record any other comments or observations you may wish to make regarding the student and his or her ability to function safely, stably, and successfully as a full time college student at this time.