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: _________

Medications Prescribed (Please provide dosages):

____
____
____
____
____

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?

___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 after being diagnosed and treated for an eating disorder
___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	Blood sugar levels
___ Yes ___ No ___N/A	Breakthrough seizures or sudden unconsciousness
___ Yes ___ No ___ N/A	Asthmatic events
___Yes ___No ___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.