2900 Purchase Street
Spellman Hall G11
Purchase, New York 10577
(914) 323-7277 or (914) 323-5155

Provider Evaluation *after* Medical Leave of Absence

To the Health Care Provider: The student named below is requesting reinstatement to Manhattanville College after having taken a medical leave of absence. The information you provide on this form will be used to determine the student's readiness to resume academic study and/or residence on campus. It is crucial that you provide as much detail as possible about the student's current level of functioning and their course of treatment during the period of the Medical Leave of Absence.

Please be advised that students returning from Medical Leave of Absence who require continued psychological or psychiatric care will be expected to have a treating provider in place at the time of reinstatement. Students returning from Medical Leave of Absence who require continued medical treatment must have a treatment plan in place.

Identifying Information

Student Name:_____

Student ID #: _____ Date of Evaluation:_____

Reason for Medical Leave of Absence: _____

Current treatment (check all that apply and specify provider):

◯Medications: _____
◯Physical therapy:_____
◯Nutritional therapy:_____
◯Individual and/or group psychotherapy:_____
◯Substance abuse treatment:_____
◯Other:_____
_____

Current Medications (with dosages):
_____
_____

Prescribed by: _____

MEDICAL LEAVE DUE TO PSYCHIATRIC REASONS (please complete the following):

Diagnoses (please use ICD-10 codes):

_____

Dates seen in therapy: _____ / _____ / _____ to _____ / _____ / _____

Frequency of appointments: _____

Total number of sessions: _____

Treatment Goals:

_____
_____
_____

Progress in Treatment (include any behaviors that hinder progress if applicable):

_____
_____
_____

Current Clinical Impressions:

_____
_____
_____

Prognosis: _____ Good _____ Fair _____ Poor

Probability of Relapse/ other concerns:

_____
_____
_____
_____

Current Risk Assessment:

	Low	Moderate	High	N/A	Unable to Assess	Comments
Suicide Risk						
Violence Risk						
Self-injury Risk						
Risk of medical instability						

MEDICAL LEAVE DUE TO PHYSICAL ILLNESS/INJURY (please complete the following):

Diagnoses (please use ICD-10 codes):

_____

Level of Impairment (please describe):

_____
_____
_____

Treatment/Medical Interventions:

_____
_____
_____

Recommendations for Continued Treatment or Management of Illness/Injury:

_____
_____
_____

*****ALL PROVIDERS MUST COMPLETE THIS PAGE**:***

Clinical Impressions and Recommendations

Has the patient been involved in activities (i.e. job, volunteer work, college courses, other) that demonstrates their improvement in overall functioning?

_____
_____
_____

Are you recommending that the patient return as a part-time or full-time student?

(check one) Full Time: _____ Part Time: _____

Why?

_____
_____

If full-time, are you recommending that the patient return as a commuter student or a residential student?

(check one) Residential Student: _____ Commuter Student: _____

Why?

_____
_____

If residential student, do you have any concerns about the patient's ability to reside with a roommate(s) or in a residence hall?

(check one) Yes: _____ No: _____

If yes, please explain:

_____
_____

What other college support services (if any) do you believe could be beneficial to this patient in ensuring their continued progress/success? (i.e. accommodations, academic resource center/tutoring center, etc)

_____
_____
_____

****ALL PROVIDERS MUST COMPLETE THIS PAGE**:**

In your opinion, is the patient able to manage the academic, physical, social, and emotional stressors that present as part of the college experience?

(choose one) Yes: _____ No: _____

Please explain:

_____
_____
_____

Recommendations for continued treatment (check all that apply and specify provider and frequency):

◯Medical: _____
◯Physical therapy: _____
◯Medications: _____
◯Nutritional therapy:_____
◯Individual and/or group therapy:_____
◯Substance Abuse Treatment:_____
◯Other:_____

Please attach any other pertinent information, recommendations, or interventions that should be considered (if applicable).

Attestation

Provider name:_____ Date:_____

Provider Practice name and address:

_____
_____

Provider signature:_____

Provider Credentials: _____ License Number: _____

Telephone number:_____ Fax Number:_____

Upon Completion, please fax or mail this form (with the signed consent forms below) to:
Manhattanville Student Health and Counseling Services
Attn: Melissa Boston, Psy.D., Associate Dean of Student Health and Counseling
2900 Purchase Street
Spellman Hall G11
Purchase, NY 10577
914-323-5155 (phone)
914-798-2701 (fax)

SHAC Counseling
2900 Purchase Street
Spellman G11
Purchase, NY 10577
Phone: (914) 323-5155
Fax: (914) 798-2701

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Full Name _____ **Patient's Date of Birth** _____

Address _____ **Patient's Telephone Number** _____

City, State Zip Code _____ **Patient's Social Security Number** _____

The following specific person/facility is authorized to use or release information about me:

MANHATTANVILLE COLLEGE SHAC COUNSELING

2900 Purchase Street Purchase NY 10577 (914)323-5155

Attn: _____

The following person/facility may receive clinical information about me:

_____

_____

_____

(Name of person or organization, address, phone number, fax number)

The specific information that should be disclosed is:

_____ Intake Assessment _____ Psychiatric Evaluation

_____ Psychological Evaluation _____ Discharge Summary

_____ Other (please specify): _____

The released information is to be used for:

_____ Evaluation and Continuing Treatment _____ Coordination of Care _____ Other: _____

Patient Authorization

I understand that my records may contain information regarding the testing, diagnosis or treatment of HIV/AIDS, sexually transmitted infections, and drug and/or alcohol abuse. I give my special authorization for this information to be released. **INITIALS: _____**

1. I understand that the information used or disclosed may be subject to re-disclosure by the person/facility receiving it, and would then no longer be protected by federal privacy regulations.
2. I understand that authorizing the disclosure of this information is voluntary. I understand that I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that I have a right to receive a copy of this authorization.
3. I may revoke this authorization at any time by notifying Manhattanville College Counseling Center in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
4. I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Record, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
5. This authorization expires on _____, 20_____ (or 1 year from when it was signed).

_____ _____

Signature of Individual **Date of Individual's Signature**

SHAC Counseling
2900 Purchase Street
Spellman G11
Purchase, NY 10577
Phone: (914) 323-5155
Fax: (914) 798-2701

AUTHORIZATION TO OBTAIN INFORMATION

Patient's Full Name _____ **Patient's Date of Birth** _____

Address _____ **Patient's Telephone Number** _____

City, State Zip Code _____ **Patient's Social Security Number** _____

The following specific person/facility is authorized to obtain information about me:
MANHATTANVILLE COLLEGE SHAC COUNSELING
2900 Purchase Street Purchase NY 10577 (914)323-5155
Attn: _____

The following person/facility may release clinical information about me:
_____
_____
_____
(Name of person or organization, address, phone number, fax number)

The specific information that should be disclosed is:

_____ Intake Assessment _____ Psychiatric Evaluation
_____ Psychological Evaluation _____ Discharge Summary
_____ Other (please specify): _____

The released information is to be used for:
_____ Evaluation and Continuing Treatment _____ Coordination of Care _____ Other: _____

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Signature of Individual **Date of Individual's Signature**