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:

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
<th>N/A</th>
<th>Unable to Assess</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide Risk</td>
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<tr>
<td>Violence Risk</td>
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<tr>
<td>Self-injury Risk</td>
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<tr>
<td>Risk of medical instability</td>
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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:
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)
_________________________________________________________________________________
_________________________________________________________________________________
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: ________________________________
□ 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: ________________

TelephoneNumber:________________________ 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)
## AUTHORIZATION FOR RELEASE OF INFORMATION

<table>
<thead>
<tr>
<th>Patient’s Full Name</th>
<th>Patient’s Date of Birth</th>
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<table>
<thead>
<tr>
<th>Address</th>
<th>Patient’s Telephone Number</th>
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<table>
<thead>
<tr>
<th>City, State Zip Code</th>
<th>Patient’s Social Security Number</th>
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</table>

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**  __________________________

Revised January 2020
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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Revised January 2020