

**BARNARD COLLEGE**

**Health Evaluation form for Readmission after Medical and/or Mental Health Withdrawal**

**To the Student:** Please review this form with your current health care or mental health care provider. This form must be submitted to the Dean of Studies office by June 1 for Fall readmission or November 1 for Spring readmission. In order to resume study at Barnard, you will be asked to demonstrate that the condition that has caused you to withdraw has sufficiently resolved to allow resumption of studies. Please be aware that you will also need to schedule an assessment interview with either the Director of Primary Care Health Services or the Furman Counseling Center prior to the start of the semester in which you wish to return to campus. Students who withdrew for medical or mental health reasons may be given housing preference, based on when they submitted their readmission forms.

**To the Health Care Provider:** The student named below is requesting readmission to Barnard College. The information you provide will be used in helping to reach a decision regarding this request. **It is of vital importance that you indicate this student's readiness to resume academic study and/or residence on campus.** Please also be as detailed as possible about the course of treatment provided to this student during the period of the leave of absence. Upon completion, please fax this form with a copy of your release of information to:

**Student Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Student ID #:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_ **Date of Diagnosis:** \_\_\_\_\_

**Duration of treatment by this provider:** \_\_\_\_\_

**Current medical and/or psychological status (please be specific):**

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**Current symptoms which might interfere with academic performance (please be specific):**

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**Current and continuing treatment modalities (please check all that apply and give details about who will provide this recommended continuing care):**

Medications: \_\_\_\_\_

Physical therapy: \_\_\_\_\_

Nutritional therapy: \_\_\_\_\_

Individual and/or group therapy: \_\_\_\_\_

In-patient treatment: \_\_\_\_\_

Other: \_\_\_\_\_

Comments:

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**Current medications:**

Medication	Date Started	Dose	Frequency	Side Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Limitations of present condition to academic performance:**

	Mild	Moderate	Severe	N/A	Comments:
Concentration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Reading	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Writing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Ability to attend class	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Other: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

**Current Risk Assessment:**

	None	Moderate	High	N/A	Unable to assess	Comments:
Risk of Medical Instability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Suicide risk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Violence Risk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Self-injury Risk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

**Previous treatment modalities (provide details for all that apply):**

	<b>Dates</b>	<b>Location/Name of Institution</b>
<input type="radio"/> Outpatient treatment	_____	_____
<input type="radio"/> Partial hospitalization	_____	_____
<input type="radio"/> Residential/inpatient treatment	_____	_____
<input type="radio"/> Surgical procedures	_____	_____

**What functional difficulties remain which may require on-going treatment or which may interfere with this student's ability to perform to her best abilities?**

- \_\_\_\_\_ Attention / Concentration Impairment
- \_\_\_\_\_ Eating Disorder
- \_\_\_\_\_ Homicidal Ideation/Intent
- \_\_\_\_\_ Interpersonal Difficulties (Axis II related problems)
- \_\_\_\_\_ Motivational Difficulties
- \_\_\_\_\_ Mood Instability
- \_\_\_\_\_ Neurovegetative Depressive Symptoms
- \_\_\_\_\_ Obsessions/Compulsions
- \_\_\_\_\_ Panic Symptoms
- \_\_\_\_\_ Post Traumatic Stress Symptoms
- \_\_\_\_\_ Psychotic Symptoms
- \_\_\_\_\_ Relationship Violence
- \_\_\_\_\_ Self-Injurious Behavior
- \_\_\_\_\_ Sleep Disturbance
- \_\_\_\_\_ Social Phobia Symptoms
- \_\_\_\_\_ Substance Abuse/Dependence
- \_\_\_\_\_ Other:

If any of the above were selected, please elaborate.

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**PROVIDER COMPLETING THIS FORM:**

Please check one or both below:

- I believe that this student is medically stable and is able to return to Barnard College as a full time student.
- I believe that this student is psychologically stable and is able to return to Barnard College as a full time student.

Please check one below and complete appropriate section:

- I have examined this student and have completed this form based upon my own personal assessment of the student's health status:

Provider name: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Practice name and address:

\_\_\_\_\_

Hospital Affiliation: \_\_\_\_\_

Provider signature: \_\_\_\_\_ License number: \_\_\_\_\_

Telephone number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

- I have not examined this student personally, but have based my assessment on a thorough review of the medical/psychological chart and/or consultation:

Provider name: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Practice name and address:

\_\_\_\_\_

Hospital Affiliation: \_\_\_\_\_

Provider signature: \_\_\_\_\_ License number: \_\_\_\_\_

Telephone number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**If the student is receiving treatment from any other providers, please indicate:**

Name of provider: \_\_\_\_\_ Telephone number: \_\_\_\_\_

**PLEASE ATTACH ANY RELEVANT INFORMATION.**