Physician or Mental Health Professional's Assessment and Recommendation Regarding Patient's Readiness for Bucknell University Reinstatement

(Please write very legibly)

Date: _____ Student ID: _____

Patient's Name: _____ DOB: _____

Physician or Mental Health Professional Providing This Report:

Name and Degree:

_____

_____Physician _____Psychiatrist _____Psychologist
_____Social Worker _____Counselor _____ Other: _____

Business Address:

_____
_____
_____

Phone: _____
Fax#: _____

Treatment Information:

Date of patient's initial appointment with you: _____

Date of patient's last appointment with you: _____

Number of times patient was seen by you since withdrawal from university:_____

Total number of times patient was seen by you (if different than above): _____

(*Check all that apply*)

Treatment modalities used: _____psychotherapy _____pharmacotherapy _____
other: specify_____

Description of symptoms at time of first appointment with you following their withdrawal:

_____

_____
Prescribed medications and dosages:

_____

Return to: Counseling & Student Development Center, Bucknell University, 1 Dent Drive, Lewisburg, PA, 17837 | FAX: 570-577-1849

Will patient be continuing with medication treatment after reinstatement? _____Yes _____No
Issues addressed in treatment with you:

_____

_____

_____

_____

_____

_____

_____

Your diagnosis of patient (DSM-5): _____

Observed changes in patient's functioning during time in treatment with you:

_____

_____

_____

_____

_____

Remaining functional difficulties which need to be addressed in continued treatment or which may pose difficulties in relation to student's reenrollment:

Check any that may apply:

_____Anxiety Symptoms
_____Attention / Concentration Impairment
_____Bipolar Mood Instability
_____Depressive Symptoms
_____Eating Disorder
_____Homicidal Ideation/Intent
_____Interpersonal Difficulties
_____Motivational Difficulties
_____Obsessions/Compulsions
_____Panic Symptoms
_____Personality Disorder
_____Posttraumatic Stress Symptoms
_____Psychotic Symptoms
_____Self-Destructive Behavior – Non-Suicidal (i.e. – cutting)
_____Sleep Disturbance
_____Social Phobia Symptoms
_____Substance Abuse/Dependence
_____Suicidal Ideation/Intent
_____Other:

_____

_____

If any difficulties were selected, please elaborate, particularly with regard to whether or not student's remaining functional difficulties may contraindicate a return to the academic environment.

_____

_____

_____

_____

_____

Your recommendation regarding patient's readiness to return to academic enrollment:

_____Student is ready to resume full-time academic reinstatement

_____Student is not ready to resume full-time enrollment, but it is recommended that they enroll part-time

_____Student is not yet ready to resume any academic enrollment.

Comments:

_____

_____

Recommended treatment plan if student returns to Bucknell University enrollment:

_____ Continued treatment is not necessary at this time

_____ Student will remain in treatment with current provider(s)

_____ Treatment should be transitioned to Bucknell University or off-campus provider(s)

Additional treatment plan comments:

_____

_____

_____ _____

Signature of Provider **Date**