MEDICAL PROVIDER FORM

˜is form is to be completed by a licensed mental health or medical provider. Information should be based on information from the last six months of the date this form was completed. **Please respond to the questions listed below and attach a brief statement of recommendation for readmission and a treatment summary on your office letterhead.**

Missouri University of Science and Technology requires that students returning from a medical leave of absence provide evidence that the condition that precipitated the need for a leave of absence has been successfully treated such that the condition no longer adversely a°ects the student's ability to successfully or safely function in the university environment. Admission holds will not be removed until we receive the paperwork from your o¿c e.

Name of the Student: ______________________________

QUESTIONS FOR HEALTH CARE PROVIDER

Did you provide treatment for the student? ☐ Yes ☐ No What dates did treatment occur? ____________

Has the student successfully completed treatment? ☐ Yes ☐ No

Did the treatment su¿cientl y address the reasons for withdrawal? ☐ Yes ☐ No

Has the student been compliant with treatment? ☐ Yes ☐ No

How many treatment sessions have you provided for the student? ______________________________

Is follow up or after care treatment recommended? ☐ Yes ☐ No

If so, please specify recommended treatment.

____

____

Can follow up or after care treatment be received utilizing existing campus or community resources? ☐ Yes ☐ No

Is there any information that was provided by the student that leads you to believe this student poses a threat of self-harm or physical harm to others? ☐ Yes ☐ No

If so, please share the information.

____

What are the continued needs of this student?

____

What areas may pose a challenge to the student?

____

What recommendations do you have for next steps to make this student as successful as possible?

____

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QUESTIONS FOR HEALTH CARE PROVIDER

Have you prescribed medications for this student? ☐ Yes ☐ No

If yes, please list medications including dosage.

____

Should the student remain on these medications upon their return? ☐ Yes ☐ No

What is your confidence in the student's ability to manage their medication?

____

How will medication management impact their success as a student?

____

What recommendations do you have for the student's living environment such as on-campus versus o° -campus, roommates versus living alone?

____

Can the student handle the academic rigors as a full time student autonomously? ☐ Yes ☐ No
If not, what are your recommendations for return?

____

Please provide any discharge paperwork or summaries.

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____

Additional Comments:

____

____

By signing I am representing to the best of my ability that the information provided is true, complete and accurate, that is constitutes my best professional judgment and opinion, and that the patient did not prepare or draft the response for my signature.

Signature of Treating Professional: ______________________ **Date:** __________

Printed Name of Treating Professional: ______________________ **Phone number:** __________

Address: ______________________________________

Professional's credentials and licensure: ______________________

Please return information to:

Krista Morris-Lehman
202 Norwood Hall, 320 W. 12th St., Rolla, MO 65409
Fax: 573-341-6107
Email: cc@mst.edu

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