

Counseling Services 300 North Washington Street College Union Building Campus Box 424 Gettysburg, Pennsylvania 17325 –1400

## Form 4

## HOME HEALTHCARE PROVIDER RECOMMENDATIONS

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

Anticipated Date of Return: \_\_\_\_\_

\*\*This form should be completed ONLY

#### between April 15 and June 1 for return in the fall semester OR

#### between <u>October 15 and December 1</u> for return in the spring semester.

The information requested below is to aid Counseling Services in evaluating this student's request to return to Gettysburg College following a Medical Leave of Absence/Withdrawal. Your comments are very useful to us. If you have any questions, please contact our office at 717-337-6960.

Please return this form to: Dr. Kathy Bradley; Director of Counseling Services; Campus Box 424; Gettysburg College; Gettysburg, PA 17325

### To be completed by the treating professional.

Printed Name:			Credentials:
Address:			
Phone:		_ Fax:	Date:

1. Please explain why this student engaged you in treatment.

# 2 [Type text]

2. What did the student communicate to you about the circumstances surrounding taking a leave from the College?

3. What was your initial clinical/diagnostic impression?

- 4. What was the duration of your treatment?
  - a. What was the date of your first visit?
  - b. What was the frequency of your treatment?
  - c. What was the date of your last visit?
- 5. Please comment on the student's compliance with treatment (attendance at appointments, compliance with treatment regimen).
- 6. What issues did you address in treatment, and how did the student respond?
- 7. Please indicate others involved in the care of this student.
  - a. Family members:
  - b. Other Professionals:
  - c. Hospitals
- Updated: Summer 2016



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- 8. Has the student been psychiatrically hospitalized (partial or full) since leaving the College? If yes, please provide dates and reasons for hospitalization:
- 9. What is your current diagnostic impression?
- 10. How stable is the student's condition?
- 11. What medications and present doses are prescribed?
  - a. b.
  - о. С
  - c.
- 12. What medications have been tried and why are they no longer being used?
  - a.
  - b.
  - c.
- 13. What recommendations for further care have you made to this student now?

4 [Type text]

14. Can you identify any specific precipitants that could put this student at risk?

15. Were issues of alcohol and other drugs addressed? \_\_\_\_\_ Are there recommendations?

16. What additional support might benefit this student in his/her performance (e.g.

special living situations, academic accommodations, structured activities, etc.)?

17. Will you continue to play a role in this student's care upon his or her return to school?

18. Please note any reservations you have about this student resuming residential study at this time.

19. Please note other important observations or comments:

(Signature)

(Date)

Updated: Summer 2016