Gettysburg College Health Services

Healthcare Provider Post-Medical Withdrawal Summary Report and Recommendations

Student Name: ______________________________ Date: ________________

Treating Healthcare Provider's Name: ____________________________________

Specialty: ____

Address: ________________________ Telephone: ________________________

________________________ Fax: ________________________

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The information requested will assist the Gettysburg College Health Services determine if this student is able to return the academic setting following a medical leave/withdrawal. If a summary letter is preferred, please include all the appropriate information below. This information will be used to assist the student in his/her return to Gettysburg College.

1. Reason student sought your medical intervention.

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2. Current diagnostic impression(s).

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   ____

3. Date of first Visit: ________________ Date of last Visit: ________________

4. Frequency of visits: ________________ Next Appointment: ________________

5. Surgical/diagnostic procedures and date performed.

   ________________________________ Date: ________________

   ________________________________ Date: ________________

6. Other treatment modalities and current medication, including dosages.

   ____

   ____

   ____

   ____

7. Impressions of stability of student's current and future health status.

   ____

   ____

   ____

Student name: ____

8. Is it your opinion the student's condition is stable enough to allow return to academic and campus life at Gettysburg College?____**Yes** ____**No**

   If **yes**, recommended date of return to campus: ______________________________

   If **no**, comment: ____

   ____

   ____

9. Will you continue to be involved in the treatment of this student upon return to Gettysburg College?_____**Yes**____**No**

10. If student is able to return to campus, what is your recommendations for additional treatment and support for the student upon return to Gettysburg College? (Including how Gettysburg College Health Services, local specialist, or Residence Life officials can assist the student upon return to the campus)

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11. Please note other important observations or comments:

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If you have any questions or concerns you would like to discuss, please feel free to contact our office.

____ ______________________
Signature of Healthcare Provider completing form Date

____
Print Name

Return form to address below or fax to: 717-337-6978

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