Gettysburg College Health Services
Healthcare Provider Post-Medical Withdrawal
Summary Report and Recommendations

Student Name: ____________________   ________________  ___________ /___/______
Last               First               MI               Date Completed

Treating Healthcare Provider’s Name: __________________________
Address: ___________________ Telephone: (_____) __________________
___________________________________________________________
___________________________________________________________
Fax (_____) __________________

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.
   ____________________________________________________________________
   ____________________________________________________________________

2. Current diagnostic impression(s).
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

3. Date of first visit: ___/___/______ Date of last visit: ___/___/______
   Frequency of visits: ______________________ Next appt.: ___/___/______

4. Surgical/diagnostic procedures and date performed.
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

5. Other treatment modalities and current medication, including dosages.
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
7. 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: ___/___/_____.

8. 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)

    ____________________________________________________________________________

    ____________________________________________________________________________

    ____________________________________________________________________________

11. Please note other important observations or comments:

    ____________________________________________________________________________

    ____________________________________________________________________________

    ____________________________________________________________________________

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:
Gettysburg College Health Service at 717-337-6978

Judith Williams, CRNP
Director Student Health Services
Gettysburg College
300 North Washington St
Campus Box 436
Gettysburg, Pa 17325