Counseling Center

Treating Mental Health Provider's Questionnaire for Students Returning from Medical Leave

PROVIDERS: This form is to be completed by the student's licensed mental health provider and mailed directly to the **SUNY Cortland Counseling Center, P.O. Box 2000, Cortland, NY 13045** or faxed to 607-753-2367. A hold was placed on the student's registration, following the student taking a Medical Leave of Absence. Prior to registering for another semester, the student's status must be reviewed, and your clinical information is required to evaluate the student's readiness to return to our campus. Please note that the Counseling Center provides brief time-limited treatment, often on a bi-weekly basis. For more information about the Center's services, please visit: Cortland.edu/sdc/counseling

Provider Name: _____ Date Form Completed: _____
License: _____ Agency (if any): _____
Address: _____
Telephone: _____Fax: _____
Student Name: _____Date of Birth: _____

A. Your treatment of the student:

1. Psychiatric ☐ Psychological ☐ Alcohol/Drug ☐ Other (specify):_____
2. Dates seen since medical leave initiated: From ___/___/___ To: ___/___/___
3. Total number of sessions/appointments attended: _____
4. Presenting Issue(s):_____
5. Diagnosis: _____
6. Current medications: _____

   _____

   _____
7. Current status (check one): ☐ Stable ☐ Unstable
8. Requires: ☐ Regular ongoing care ☐ Periodic follow-up

   Recommended frequency of continuing care:_____
9. Prognosis (check one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor
10. Will you continue to provide services for this student:

    ☐ Yes ☐ No ☐ no further treatment required
11. If needed, to whom will this student's care be transferred? _____
12. Anticipated date of return to SUNY Cortland: _____

NOTE TO PROVIDERS: *If a withdrawal occurs for psychological reasons, it is typically anticipated that the student will not enroll during the following semester and will use that time to obtain treatment to address or resolve the condition that required the withdrawal. A student must receive treatment from a licensed/certified mental health professional (e.g., psychiatrist, psychologist, social worker).*

B. Your assessment of the student's readiness to return to SUNY Cortland:
   1. Please specify the reasons why you believe that the student is ready to resume the role of student: _____
      _____
      _____
      _____
      _____

   2. Do you believe that this student is currently, or in the reasonably foreseeable future, a threat to themselves or others? ☐ YES ☐ NO
      Please explain: _____
      _____
      _____

   3. Has the student demonstrated the ability to function autonomously, in a job, a volunteer position, college course or other position which is supervised and evaluated or graded?
      Please explain:_____
      _____
      _____
      _____

   4. Is this student ready to function independently and reside in a peer living situation? (e.g., can the student make their own appointments, advocate for self with others, manage conflicts or emotional upheavals, etc.): ☐ YES ☐ NO (Please explain):
      _____
      _____
      _____
      _____

Based on the above documentation, it is my professional opinion that the student is clinically stable and is able to re-enter SUNY Cortland to resume academic responsibilities at this time.

☐ YES ☐ NO ☐ Unable to certify due to insufficient information

_____ _____

Signature Date

_____

Printed Name and Credentials/Degree