New College
THE HONORS COLLEGE of Florida

Counseling and Wellness Center

Mental Health Provider Report

This form must be completed by the student's licensed provider. It provides assurance that the student followed through with treatment and is ready to return to school. This form must be mailed to the Counseling and Wellness Center by the provider directly to:

Counseling and Wellness Center
New College of Florida
5800 Bay Shore Road
Sarasota, FL 34243
T: (941) 487-4254 F: (941) 487-4256

Provider Name: _____
Licensed as_____
Licensure State and #:_____

Student Name: _____
Date of first session: _____
Date of most recent session: _____
Total # treatment sessions: _____

Initial DSM 5 Diagnosis:

_____
_____
_____

Current DSM 5 Diagnosis:

_____
_____
_____

Medications: (include dose, length of time on medication, and length of time student has been stabilized on current dose):

_____
_____
_____
_____

Please provide your professional judgment in response to the following questions regarding the student named above.

☐ Yes☐ No There has been a substantial amelioration of the student's original medical/mental health condition.

If yes, please check all the following that you have observed a marked reduction of in this student:

☐ Number of symptoms ☐ Severity of symptoms
☐ Persistence of symptoms ☐ Functional impairment
☐ Subjective level of distress

☐ Yes☐ No The student's substantially improved condition has been maintained.

Has there been a substantial reduction of any in any of the following safety-related behaviors the student may have engaged in?

☐Yes	☐ No	☐ N/A	Suicidal behaviors
☐Yes	☐ No	☐ N/A	Self-injury behaviors
☐Yes	☐ No	☐ N/A	Substance abuse behaviors
☐Yes	☐ No	☐ N/A	Failure to maintain a medically healthy weight
☐Yes	☐ No	☐ N/A	Food binging
☐Yes	☐ No	☐ N/A	Food purging and/or potentially harmful compensatory behaviors for the purpose of weight management
☐Yes	☐ No	☐ N/A	Other:_____
☐Yes	☐ No	☐ N/A	The student's substantially improved safety-related behaviors has been maintained.
☐Yes	☐ No		The student followed all treatment recommendations?

Please provide a brief narrative indicating the degree to which issues have been resolved and the student's ability to function in a safe and stable manner to promote their ability to be successful as a full time student in an undergraduate college program at this time.

Please list any potential concerns you foresee for the student.

Please list any recommendations for continued care including mental health treatment, academics, ability to live independently and participate in residential life in the residence halls, social skills, etc. (* *Please be aware that the New College Counseling and Wellness Center utilizes a short-term, episodic care model, and refers students to the community for on-going care needs. Therefore, regular therapy and psychiatry services through the Center cannot be cited as a contingency in determining readiness to return to school*.)

Will the student continue to seek treatment with you? ☐ Yes ☐ No
(If "no" please provide the contact information for whom the student was referred)

_____ _____
Provider Signature Date

Address:_____

Telephone:_____ Email:_____