

**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. The form must be mailed to the Dean of Students by the provider directly to:

Division of Student Affairs/Dean of Students

Anne E. Fisher, Ph.D.

New College of Florida

5800 Bay Shore Road

Sarasota, FL 34243

Phone: (941) 487-4250 Fax: (941) 487-4217

Provider Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Licensed as:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of first session:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Licensure State and #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of most recent session:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total # of treatment sessions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initial DSM 5 Diagnsis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current DSM 5 Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications: (Please include dose, length of time on medication and length of time student has stabilized on current medication.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

⃝ YES ⃝ NO There has been substantial amelioration of the student’s original medical/mental health condition.

If “yes,” please check all of the following areas in which you have observed a marked reduction:

⃝ Number of symptoms ⃝ Severity of symptoms ⃝ Persistence of symptoms

⃝ Subjective level of distress ⃝ Functional impairment

Has there been a substantial reduction in the student’s engagement in any of these safety related behaviors?

⃝ YES ⃝ NO ⃝ N/A Suicidal behaviors

⃝ YES ⃝ NO ⃝ N/A Self-injury behaviors

⃝ YES ⃝ NO ⃝ N/A Substance abuse behaviors

⃝ YES ⃝ NO ⃝ N/A Maintain medically healthy weight

⃝ YES ⃝ NO ⃝ N/A Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide a brief narrative indicating the degree to which issues have been resolved and the student’s ability to function at this time. If the student is not yet ready to return, please state this here, as well as projected plan for return to college.

Please list any potential concerns you foresee for this 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 contact information for the professional to whom student was referred)

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Provider Signature Date

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_