COMMUNITY PROVIDER REPORT FORM

NOTE: This form is to be completed by the student’s community mental health clinician/service provider and mailed by the provider directly to the Student Affairs office at the address indicated above.

Provider’s Name: _______________________________ Student Name_____________________

Licensed as ______________________________ Date of First Session __________________

License # ______________________________ Date of Most Recent Session________________

State of Licensure _________________________ Total # of Treatment Sessions________________

Initial DSM Axis I Diagnosis Initial DSM Axis V Diagnosis

______________________________________________________________________________

Current DSM Axis I Diagnosis Current DSM Axis V Diagnosis

______________________________________________________________________________

Other Diagnoses or Clinical Issues

______________________________________________________________________________

Please provide your professional judgment in response to the following questions:

___ Yes ___ No Has there been a substantial amelioration of the student’s original medical/psychological condition?

If yes, please check all of 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 client distress

___ Yes ___ No If achieved, has the substantially improved condition been maintained stably for three consecutive months?

Has there been a substantial reduction of any of the following safety related behaviors (mark N/A if not applicable)?

___ 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 weight at minimum of 90% of Ideal Body Weight for height

___ Yes ___ No ___ N/A Food binging

___ Yes ___ No ___ N/A Food purging or any other potentially harmful compensatory behaviors used for weight management (e.g., use of laxatives, excessive exercise, etc.)

___ Yes ___ No ___ N/A Other:

___ Yes ___ No If achieved, has the substantial reduction in safety related behaviors been maintained stably for three consecutive months?

Additional Comments:

Clinician Signature __________________________________________ Date________________________