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 Counseling Center Staff 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 ____________________________