

UNIVERSITY OF TAMPA STUDENT HEALTH & COUNSELING CENTER

TREATING PHYSICIAN OR LICENSED MENTAL HEALTH PROFESSIONALS RE-ENROLLEMENT QUESTIONNAIRE

Instructions: This form is to be completed only by the treating physician, psychiatrist, licensed psychologist or other mental health professional. Please respond to the questions listed below and attach a brief statement of recommendation for re-enrollment on your office letterhead. Please send the completed form and statement to the address indicated below.

On occasion, a student is required to take a leave of absence and/or is prohibited from re-enrollment at The University of Tampa for medical/psychological reasons. This procedure is employed only after all available College resources have been pursued in an attempt to reduce or remedy the student's medical/psychological problem. Therefore, it is the policy of The University of Tampa that any student prohibited from re-enrollment for medical/psychological reasons from this or any other institution must have this form completed by a physician or mental health professional and submitted to The University of Tampa for approval before the student will be permitted to re-enroll.

If the problem is medical, a physician must complete the form. If the problem is psychological, a psychiatrist, licensed psychologist or other licensed mental health professional must complete the form. If a student seeks an evaluation from a community mental health clinic, it is understood that he or she may be seen by psychologists, social workers, or counselors with the option of being evaluated by a psychiatrist for medication or further diagnosis. If the student has been hospitalized, personnel on the hospital treatment team may appropriately complete this questionnaire. **In any event, the form must be completed and signed by a physician (if medical) or by a psychiatrist, licensed psychologist or other treating mental health professional (if psychological) and the evaluation must consist of a minimum of eight psychotherapy sessions or eight medication checks by a psychiatrist.**

1. Full name of student & ID # _____
2.
 - a. Are you a ____ medical doctor, or ____ psychiatrist, or ____ licensed psychologist
____ social worker ____ masters level counselor?
 - b. Did you provide the treatment for the above named student? ____ Yes ____ No
 - c. How many treatment sessions have you provided for the student (relating to this matter)? ____
 - d. When did the treatment commence? _____ Conclude? _____ Ongoing? _____
 - e. Has the above named student completed treatment? ____ Yes ____ No

3. Briefly describe the student's problems as you see them and include all diagnosis, if applicable. (Axis I, II, III, IV, V). Please feel free to attach a separate page if necessary.

4. Have you referred the student for continuing treatment? ____ Yes ____ No
If yes, please indicate the name, address, and phone number of the individual or agency. You may wish to consult with the Student Health and Counseling Center regarding the availability and appropriateness of referral resources in the community or you may choose to have the student consult the Health and Counseling Center for referrals. **Please keep in mind that The University of Tampa Counseling Center is a SHORT-TERM, solution-based center, and that a referral to it for long-term psychotherapy is inappropriate for the student. Students needing long-term psychotherapy are referred to a community mental health professional. Students are responsible for providing their own transportation to these appointments and are required to confirm proof of treatment through informed consent between the community provider and the Student Health and Counseling Center.**

5. What would continuing treatment for this student entail?

6. If you referred the student for continuing treatment, do you believe he/she would be able to function appropriately as a student at this College without continued treatment?
____ Yes ____ No

7. Do you consider that the student presently or in the reasonably foreseeable future may be a threat to his/her own life or the lives of others? ____ Yes ____ No Comments:

8. Does the student require medication in order to function effectively?
_____ Yes _____ No. If yes, please describe medication treatment program and how the student will access medications.

9. Do you think this student is capable of carrying a full academic load (12 – 18 credit hours) ? _____ Yes _____ No

10. Would you recommend that the student live in?

- _____ a) Campus residence halls.
_____ b) Off-campus private housing.
_____ c) Live at home and commute (if feasible).

Please explain the reasons for your recommendation.

11. To your knowledge, are the parents and/or legal guardians of the student aware of the problem(s) for which you have provided treatment? _____ Yes _____ No

12. Other comments:

Signature of Treating Professional

Date

Please remember to attach a brief statement of recommendation for re-enrollment using your office letterhead. Return to: The University of Tampa Student Health and Counseling Center, 401 W. Kennedy Blvd., Tampa, Florida 33606. Phone number 813-253-6250.

