Graduate Student Health Clearance Form
University of Tampa

TREATING PHYSICIAN, PA, APRN OR LICENSED MENTAL HEALTH PROFESSIONALS 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 medical clearance for re-enrollment **on your office letterhead.**

Please return to:

Sean McLawhorn, MS, LMHC
Health Clearance Committee
Clinical Case Manager
401 W. Kennedy Blvd.
Box 116F
Tampa, Florida 33606.

You may also confidentially fax this form to (813) 258-7413.

On occasion, a student, for medical/psychological reasons, chooses to take a leave of absence and/or is prevented from re-enrollment at The University of Tampa through a Spartan Support Program hold. This procedure is employed only after all available University resources have been pursued in an attempt to reduce or remedy the student's medical/psychological issue while still enrolled. Therefore, it is the policy of The University of Tampa, that any student prevented from re-enrollment for medical/psychological reasons in 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 by the Medical Clearance Committee 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 of 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, licensed therapist with a certification in addictions or other treating mental health professional (if psychological) and the evaluation must consist of a minimum of eight sessions and/or medication checks. If substance abuse dependency treatment was warranted, it is recommended that the student demonstrate successful completion of treatment and successful sobriety and/or abstinence from other drugs for a minimum of 1 full year.**

1. Full name of graduate student & ID _____
Graduate student's current email address _____
Graduate student's current phone number _____

2. a. Please provide professional credentials including professional license number and state of licensure.

_____
_____
_____

b. Did you provide the treatment for the above-named graduate student? Yes___ No___
c. How many treatment sessions have you provided for the graduate student (relating to this matter)? _____

d. When did the treatment commence? _____

Is this ongoing? _____
If concluded--what date was last service?_____

3. Briefly describe the graduate student's problems as you see them and include all diagnosis, if applicable. Please feel free to attach a separate page if necessary.

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4. Have you referred the graduate 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 Dickey Health and Wellness Center regarding the availability and appropriateness of referral resources in the community or you may choose to have the student consult the Dickey Health and Wellness Center for referrals.

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Please keep in mind that The University of Tampa Dickey Health and Wellness Center is a SHORT –TERM, solution-based center and may not be used as a referral for long-term psychotherapy. 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 Dickey Health and Wellness Center.

5. What would continuing treatment for this graduate student entail? If substance abuse is an issue, please share aftercare plan. Attach additional sheets if necessary.

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6. If you referred the graduate student for continuing treatment, do you believe the graduate student would be able to function appropriately as a student at the University of Tampa without continuing treatment? Yes____ No____

7. Please comment on the graduate student's current functioning.

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8. a. Do you consider that the graduate student presently or in the reasonably foreseeable future may be a threat to their own life or the lives of others? Yes_____ No _____

b. Is the graduate student currently exhibiting any harmful or self-harming behaviors? Yes_____ No_____ Comments: _____

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9. Does the graduate student require medication in order to function effectively? Yes___ No ___
If yes, please describe medication treatment program and how the student will access medications.

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10. Do you think this graduate student is capable of carrying a full graduate academic load?

Yes_____ No_____ Please explain reasoning:

_____

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_____

12. As graduate student ages are variable, please answer only if applicable: To your knowledge, are the parents and/or legal guardians of the student aware of the issue(s) for which you have provided treatment? ___ Yes ___ No

13. Other Comments:

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Signature of Treating Professional Date