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:
Clinical Case Manager
Health Clearance Committee
401 W. Kennedy Blvd.
Box 116F
Tampa, Florida 33606.

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

On occasion, a student may take a leave of absence, be involuntarily withdrawn, or be prevented from re-enrolling at The University of Tampa due to medical and/or psychological reasons, including placement of a Spartan Support Program hold. Such action is taken only after all available University resources have been exhausted in an effort to address the student's medical or psychological needs while the student remains enrolled.

Accordingly, it is the policy of The University of Tampa that any student who has been prevented from re-enrolling for medical and/or psychological reasons must have this form completed by an appropriate medical or mental health professional. The completed form must be submitted to The University of Tampa and approved by the Clearance Committee before the student will be permitted to re-enroll.

If the concern is medical in nature, the form must be completed by a licensed physician. If the concern is psychological, the form must be completed by a psychiatrist, licensed psychologist, or other appropriately licensed mental health professional. Students who seek evaluation through a community mental health clinic may be seen by psychologists, social workers, or counselors and may also be evaluated by a psychiatrist for medication management or further diagnosis. If the student has been hospitalized, a member of the hospital treatment team may complete this form.

In all cases, the form must be completed and signed by the medical professional who treated and/or discharged the student: a physician for medical concerns, or a psychiatrist, licensed psychologist, licensed therapist with certification in addictions, or other licensed treating mental health professional for psychological concerns.

1. Full name of student & ID #_____
Student's current email address _____
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 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 diagnoses, if applicable. Please feel free to attach a separate page if necessary.

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_____
_____
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_____

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 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 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 student for continuing treatment, do you believe the student would be able to function appropriately as a student at the University of Tampa without continued treatment?____ Yes ____ No

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

_____
_____
_____

8. a. Do you consider that the 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 student currently exhibiting any harmful or self-harming behaviors? _____ Yes _____ No
Comments:

_____
_____
_____

9. 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.

_____
_____
_____

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

11. In which type of housing would you recommend the student live?
_____ a. Campus residence halls.
_____ b. Off-campus private housing.
_____ c. Live at home or with extended family and commute.

Please explain the reasons for your recommendation.

_____
_____
_____

12. 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