

# MEDICAL PROVIDER FORM

This form is to be completed by a licensed mental health or medical provider. Information should be based on information from the last six months of the date this form was completed. Please respond to the questions listed below and attach a brief statement of recommendation for readmission and a treatment summary on your office letterhead.

Missouri University of Science and Technology requires that students returning from a medical leave of absence provide evidence that the condition that precipitated the need for a leave of absence has been successfully treated such that the condition no longer adversely affects the student's ability to successfully or safely function in the university environment. Admission holds will not be removed until we receive the paperwork from your provider.

**Name of the Student:** \_\_\_\_\_

## QUESTIONS FOR HEALTH CARE PROVIDER

Did you provide treatment for the student?  Yes  No What dates did treatment occur? \_\_\_\_\_

Has the student successfully completed treatment?  Yes  No

Did the treatment sufficiently address the reasons for withdrawal? Yes  No

Has the student been compliant with treatment?  Yes  No

How many treatment sessions have you provided for the student? \_\_\_\_\_

Is follow up or after care treatment recommended?  Yes  No

If so, please specify recommended treatment.

Can follow up or after care treatment be received utilizing existing campus or community resources?

Yes  No

Do believe this student poses a threat of self-harm or physical harm to others?  Yes  No

If so, please share the information.

What are the continued needs of this student?

What areas may pose a challenge to the student?

What recommendations do you have for next steps to make this student as successful as possible?

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Have you prescribed medications for this student?  Yes  No

If yes, please list medications including dosage.

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Should the student remain on these medications upon their return?  Yes  No

What is your confidence in the student's ability to manage their medication?

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How will medication management impact their success as a student?

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What recommendations do you have for the student's living environment such as on-campus versus off-campus, roommates versus living alone?

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Can the student handle the academic rigors as a full-time student autonomously?  Yes  No  
If not, what are your recommendations for return?

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Please provide any discharge paperwork or summaries.

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Additional Comments:

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By signing I am representing to the best of my ability that the information provided is true, complete and accurate, that is constitutes my best professional judgment and opinion, and that the patient did not prepare or draft the response for my signature.

Signature of Treating Professional: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Treating Professional: \_\_\_\_\_ Phone number: \_\_\_\_\_

Address: \_\_\_\_\_

Professional's credentials and licensure: \_\_\_\_\_

Please return information to:

Case Management Services  
204 Norwood Hall, 320 W. 12<sup>th</sup> St., Rolla, MO 65409  
Fax: 573-341-4211  
Email: wellbeing@mst.edu