

Health Evaluation form for Reinstatement after Medical Leave of Absence

To the Student:

In order to resume study at Washington University, you will be asked to demonstrate that the condition that has caused you to withdraw has sufficiently resolved to allow resumption of studies. To facilitate this process, your health care provider(s) must provide SHS with a completed and signed copy of this form. If you are under the care of more than one health care provider, such as a psychiatrist and therapist, a form from all providers is required.

Enter your name and date of birth below. The rest of the form is to be completed by a health care provider. Be aware that there are multiple steps to the reinstatement process including completion of this form. Please refer to the Medical Leave of Absence policy for specifics and deadlines.

To the Health Care Provider:

The student named below is requesting reinstatement from a medical leave of absence. The information you provide will be used in helping to reach a decision regarding this request. ***It is of vital importance that you indicate this student's readiness to resume academic study and/or residence on campus.*** Please be as detailed as possible.

A digital version (Adobe PDF) version of this form is available at: <http://shs.wustl.edu/FormsAndResources/Pages/Medical-Leave-of-Absence.aspx>. Instructions: Once you have the file open in Adobe, click the "Fill & Sign" button located on the upper right side of the screen. Then select "Add Text" from the options listed on the right, move the cursor to the where you to start entering text, and type your responses. You can also "Add Checkmark" and "Add Signature" from list of options on the right. When you are finished be sure to save the file before closing.

Upon completion, fax this form to Washington University Student Health Services at (314) 935-5781, or email to studentmedleave@wustl.edu with the understanding that email is not necessarily a secure method of communication. Thank you for your assistance.

Student Name: _____ **Date of Birth:** _____

Current Diagnoses (list all)

Diagnosis: _____	Date of Diagnosis: _____
Diagnosis: _____	Date of Diagnosis: _____
Diagnosis: _____	Date of Diagnosis: _____
Diagnosis: _____	Date of Diagnosis: _____
Diagnosis: _____	Date of Diagnosis: _____

Note: If one or more of the above diagnoses was that of an eating disorder, and treatment for eating disorder is what necessitated the student's medical leave, attach the following information:

- Complete history of the eating disorder (with explanation of severity of behaviors);
- Report of physical exam; Height and weight parameters and vital signs for the last 3-6 months (depending on duration of leave);
- EKG and labs: CMP, CBC, amylase, urinalysis, magnesium, and phosphorus.

Treatment Dates and Frequency with this Provider

Date of First Appointment: _____ Date of Most Recent Appointment: _____
 Number of Appointments: _____ Frequency (weekly, biweekly, monthly): _____

Brief Summary of Current Medical and/or Psychological Status (please be specific)

Current Functional Difficulties/Symptoms which Might Interfere with Academic Performance

- | | |
|---|--|
| <input type="checkbox"/> Attention / Concentration Impairment
<input type="checkbox"/> Auditory Difficulty
<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Homicidal Ideation/Intent
<input type="checkbox"/> Interpersonal Difficulties (Axis II related problems)
<input type="checkbox"/> Motivational Difficulties
<input type="checkbox"/> Mood Instability
<input type="checkbox"/> Neurovegetative Depressive Symptoms
<input type="checkbox"/> Obsessions/Compulsions
<input type="checkbox"/> Panic Symptoms
<input type="checkbox"/> Other: _____ | <input type="checkbox"/> Physical Impairment
<input type="checkbox"/> Post-Traumatic Stress Symptoms
<input type="checkbox"/> Psychotic Symptoms
<input type="checkbox"/> Relationship Violence
<input type="checkbox"/> Self-Injurious Behavior
<input type="checkbox"/> Sleep Disturbance
<input type="checkbox"/> Social Phobia Symptoms
<input type="checkbox"/> Substance Abuse/Dependence
<input type="checkbox"/> Visual Difficulty |
|---|--|

If any of the above were selected, please elaborate.

Limitations of Present Condition to Academic Performance:

	Mild	Moderate	Severe	N/A	Comments
Concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ability to attend class	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Test taking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Current Risk Assessment

	Mild	Moderate	Severe	N/A	Unable to Assess	Comments
Risk of Medical Instability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Suicide Risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Violence Risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Self-Injury Risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Additional Comments:	
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Treatment Modalities (Check all that apply)

Medication	<input type="checkbox"/> previous	<input type="checkbox"/> current	<input type="checkbox"/> recommended
Individual therapy	<input type="checkbox"/> previous	<input type="checkbox"/> current	<input type="checkbox"/> recommended
Group therapy	<input type="checkbox"/> previous	<input type="checkbox"/> current	<input type="checkbox"/> recommended
Residential/ inpatient treatment	<input type="checkbox"/> previous	<input type="checkbox"/> current	<input type="checkbox"/> recommended
	Type, provider and dates:	Type and provider:	Type and provider:
Outpatient treatment	<input type="checkbox"/> previous	<input type="checkbox"/> current	<input type="checkbox"/> recommended
	Type, provider and dates:	Type and provider:	Type and provider:
Hospitalization	<input type="checkbox"/> previous	<input type="checkbox"/> current	<input type="checkbox"/> recommended
	Type, provider and dates:	Type and provider:	Type and provider:
Nutritional therapy	<input type="checkbox"/> previous	<input type="checkbox"/> current	<input type="checkbox"/> recommended
	Type, provider and dates:	Type and provider:	Type and provider:
Physical therapy	<input type="checkbox"/> previous	<input type="checkbox"/> current	<input type="checkbox"/> recommended
	Type, provider and dates:	Type and provider:	Type and provider:
Surgeries/ procedures	<input type="checkbox"/> previous	<input type="checkbox"/> current	<input type="checkbox"/> recommended
	Type, provider and dates:	Type and provider:	Type and provider:
Other:			

Last Name, First Name: _____

To your knowledge, has the student successfully completed any coursework, internships, or employment while on leave?

If the student returns to school, what recommendations do you have for continuing treatment?

(Check any modalities you recommend on the previous page and write in specifics below)

Does the student have any special needs regarding housing? (single vs. double room, on-campus, etc.)

Is the student ready for full-time course load or do you recommend a reduced course load?

(undergraduate full-time= 12 credits/4 classes; graduate full-time= 9 credits/3 classes)

Current Medications

Medication	Date Started	Dosage	Frequency

Additional Comments or Concerns:

Provider Attestation

Check and complete one or both options below:

- I believe that this student IS or IS NOT **medically** stable and therefore ABLE or NOT ABLE to return to Washington University as a student.

- I believe that this student IS or IS NOT **psychologically** stable and therefore ABLE or NOT ABLE to return to Washington University as a student.

Check and complete one option below:

- I have examined this student and have completed this form based upon my own personal assessment of the student's health status:

Provider Name: _____ License #: _____

Provider Signature: _____

Date: _____ Phone: _____ Fax: _____

- I have not examined this student personally, but have based my assessment on a thorough review of the medical/psychological chart and/or consultation:

Provider Name: _____ License #: _____

Provider Signature: _____

Date: _____ Phone: _____ Fax: _____

If the student is receiving treatment from any other providers, please indicate:

Provider Name: _____ Phone: _____

Provider Name: _____ Phone: _____

Provider Name: _____ Phone: _____

PLEASE ATTACH ANY RELEVANT INFORMATION