Office of Disability Services

Phone: 804-862-6100 x6235

Health Care Provider Assessment Form (Psychological)

Student Name:

Person providing this assessment:

MD (Psychiatrist) Psychologist Social Worker Licensed Counselor (Circle all that apply)

Other:

State of Licensure: Phone Number:

License Number: Fax:

# Section A

Date of initial appointment: Date of most recent appointment:

Total number of times you have seen the student: Treatment modalities provided:

Psychotherapy Pharmacotherapy

Other:

Diagnostic Impressions:

Prognosis:

Current Medications and Dosages:

# Section B

Please record the symptoms that the student has demonstrated. Circle the appropriate response for each.

|  |  |  |
| --- | --- | --- |
| Symptoms observed  | Symptoms addressed by the treatment provided by you | Remaining symptoms which may periodically impact academic functioning |
| Attention & ConcentrationDifficulties | Yes | No | N/A | Yes | No | N/A | Yes | No | N/A |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Body Image/Eating Issues | Yes | No | N/A | Yes | No | N/A | Yes | No | N/A |
| Depressive Symptoms | Yes | No | N/A | Yes | No | N/A | Yes | No | N/A |
| Homicidal Ideation/Intent | Yes | No | N/A | Yes | No | N/A | Yes | No | N/A |
| Interpersonal Difficulties | Yes | No | N/A | Yes | No | N/A | Yes | No | N/A |
| Mood Instability | Yes | No | N/A | Yes | No | N/A | Yes | No | N/A |
| Motivational Difficulties | Yes | No | N/A | Yes | No | N/A | Yes | No | N/A |
| Obsessions/Compulsions | Yes | No | N/A | Yes | No | N/A | Yes | No | N/A |
| Panic Symptoms | Yes | No | N/A | Yes | No | N/A | Yes | No | N/A |
| Post Traumatic Symptoms | Yes | No | N/A | Yes | No | N/A | Yes | No | N/A |
| Psychosis | Yes | No | N/A | Yes | No | N/A | Yes | No | N/A |
| Self-Harming (non-suicidal) | Yes | No | N/A | Yes | No | N/A | Yes | No | N/A |
| Sleep Disturbance | Yes | No | N/A | Yes | No | N/A | Yes | No | N/A |
| Social Phobia | Yes | No | N/A | Yes | No | N/A | Yes | No | N/A |
| Substance Abuse/Dependence | Yes | No | N/A | Yes | No | N/A | Yes | No | N/A |
| Suicidal Ideation/Intent | Yes | No | N/A | Yes | No | N/A | Yes | No | N/A |
| Other: | Yes | No | N/A | Yes | No | N/A | Yes | No | N/A |

Does the student appear capable of functioning autonomously and successfully in a rigorous full-time academic environment (4 courses)? Yes No N/A Comments:

Is follow up and/or after care treatment recommended, or reasonable ADA accommodations? If yes, please specify type(s) of recommended treatment: Yes No N/A Comments:

Provide your opinion of student’s readiness for academic enrollment at RBC and provide explanation in the space provided below for comments:

Ability to resume full-time academic enrollment and residential living or off-campus living:

Academic responsibility often consists of 12-15 credits of rigorous academic course loads, 3-5 extracurricular activities often with leadership responsibilities, and possible athletics and/or research involvement. Residential living is either alone or with roommates/dorm living where student must maintain all activities of daily living without supervision. Off-Campus living will include all activities of daily functioning independently without supervision.

Student is ready to resume full-time academic enrollment and residential living if available.

Ability to engage in full-time academic enrollment but noott residential living:

Academic responsibilities are outlined above, however, this may mean you do not feel student is able to live within a dorm environment due to interpersonal conflicts connected with mental health symptoms and/or may require some level of supervision with managing aspects of their treatment plan or daily activities.

Student is ready to pursue full-time academic enrollment, and is not ready to live in residence.

Student is not ready to engage in academic enrollment or residential living:

Student has demonstrated that they are unable to manage symptoms without significant support in managing continued treatment plan, unable to live independently without regular supervision, and/or have significant interpersonal concerns due to mental health/safety that would be disruptive to the learning and living environments of others until better managed.

Student is not yet ready to engage in academic enrollment.

Comments:

Please include/attach a detailed treatment summary of the issues addressed in therapy as well as this student’s progress.

# Section C

By signing where indicated below I am representing to Richard Bland College that my response to each question listed above is true, complete, and accurate to the best of my knowledge and belief, this it constitutes my best professional judgment and opinion, and that the Patient did not prepare or draft that response for my signature.

Signature: Date:

Please attach your business card to this form. Please scan and email this form to the Office of Disability Services (dpayton@rbc.edu)

If you have any questions, please contact RBC’s ADA Coordinator at 804-862-6100 x 6235.