

HEALTH EVALUATION FORM

For
Medical Withdrawal
University of California, Berkeley
(To be completed by medical provider)

Upon completion, **please mail or fax this form and a copy of your Release of Information directly to our office** at: University Health Services, Social Services, 2222 Bancroft Way, room 2280, Berkeley, CA 94720, phone 510-642-6074, fax 510-643-0211, this is a confidential fax machine. **If this form is given to the student for hand delivery, please place in a sealed letterhead envelope and sign the outside seal.**

The student named below is requesting a medical leave from the University of California, Berkeley. The information you provide will be used in helping reach a determination. It will not become a part of the student's academic or health record, but will be retained in a separate administrative file.

TO BE COMPLETED BY STUDENT		
Student Name (Last, First, MI):		Date:
Term: <input type="checkbox"/> Fall <input type="checkbox"/> Spring Semester: 20_____	Student ID#:	DOB:
THE FOLLOWING INFORMATION SHOULD COMPLETED BY TREATING PROVIDER ONLY		
Diagnosis:	Date of Diagnosis:	

Check below any condition that would interfere with student academic performance:

	Mild	Moderate	Significant	Severe	N/A
Concentrating	<input type="checkbox"/>				
Reading	<input type="checkbox"/>				
Writing	<input type="checkbox"/>				
Ability to attend class	<input type="checkbox"/>				
Other _____	<input type="checkbox"/>				

Risk Assessment (Check those which currently apply):

	Not at all	Mild	Moderate	Severe	Current or	Past (date): _____	Unable to assess
Risk of medical instability	<input type="checkbox"/>						
Risk of suicide:	<input type="checkbox"/>						
Risk of violence:	<input type="checkbox"/>						
Self-injurious behavior:	<input type="checkbox"/>						

Treatment History (Check all that apply):

<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Substance abuse	<input type="checkbox"/> Medical	<input type="checkbox"/> Evaluation only
Outpatient treatment within:	<input type="checkbox"/> 6 months	<input type="checkbox"/> 1 year	<input type="checkbox"/> 2-5 years
Partial Hospitalization or Day Care within:	<input type="checkbox"/> 6 months	<input type="checkbox"/> 1 year	<input type="checkbox"/> 2-5 years
Residential Treatment within:	<input type="checkbox"/> 6 months	<input type="checkbox"/> 1 year	<input type="checkbox"/> 2-5 years
Inpatient Treatment (overnight admission) within:	<input type="checkbox"/> 6 months	<input type="checkbox"/> 1 year	<input type="checkbox"/> 2-5 years
Surgery for present illness within:	<input type="checkbox"/> 6 months	<input type="checkbox"/> 1 year	<input type="checkbox"/> 2-5 years

For hospitalization stay or emergency room visit, please include discharge summary with this form

Comment:

Treatment Progress: Beginning date: _____ How often seen: _____
of appts. to date: _____ # of appts. in semester withdrawal request is for: _____ # of appts. to complete treatment: _____

Is patient actively participating in treatment on a regular basis? Yes No

Current condition: Unstable Partially stable Stable (# of weeks _____) Date of last appt: _____

Daily activities impaired: Not at all Mildly Moderately Severely

Comment:

Continue on other side

Treatment Approach: (Check all that apply):

- Individual Psychotherapy
 Group therapy
 Medication
 Pain management
 Bed rest
 Physical Therapy
 Nutritional Therapy
 Other forms of treatment or community services being utilized:
 Yes
 No

If yes, please specify: _____

Symptoms which make or made student unable to continue studies. What is the current status of these symptoms?

Please specify: _____

Substance Use/Abuse:
 Active
 In Remission
 N/A

Symptoms have been present for as long as:
 0-6 months
 6-12 months
 more than 12 months

Medications/Labs:

Labs:
 N/A
 Normal
 Abnormal (please describe): _____

Is student currently taking medications for above symptoms? Yes
 No
 Student declines

If yes, is student compliant with medication?
 Yes
 No

Please describe medication (s), date (s) prescribed, and side effects. _____

Treatment Recommendation: _____

I have not examined this individual personally, but have based my assessment on a thorough review of the medical chart and/or consultation with the treating provider.

Name of Person Completing Form (if not provider):		Date:
Signature:	License No. (if applicable):	
Name of Institute:	Telephone No:	Fax No:

I have examined this individual and have completed this form based upon my own personal assessment of the individual's health status.

Provider Name:		Date:
Provider Signature:	License No.	
Name of Institute:	Telephone No.	Fax No.

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

Provider Name:	Telephone No.
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Please attach any relevant information that would help us make a decision.