Provider Treatment Assessment and Recommendations for Return to Emory University from Medical Leave of Absence
Emory University

Student Name: _____ Student ID: _____

PART 2: TO BE COMPLETED BY A LICENSED TREATMENT PROVIDER

- Your patient, an Emory University student, is seeking re-enrollment following a medical leave of absence. This form is required for re-enrollment and will be reviewed by necessary campus partners as part of the return process. For further information regarding the medical leave process or for any questions, please email medicalrecords-shs@emory.edu.
- This form must be signed (no electronic signatures except for Docusign) and completed by a licensed provider who is currently providing care to the student and who is not related to the student.
- No other medical/mental health notes or documentation are required.
- **Please complete in full and email as an attachment to medicalrecords-shs@emory.edu.**

Provider's Name:_____ Specialty: _____

Professional License: __MD __DO __PhD __PsyD__LCSW __LPC ___LMFT___NP ___PA

State or country of licensure:_____License number: _____

Provider Phone Number: _____
Provider Email: _____
Dates of treatment: from _____to _____ Number appointments attended: _____

Diagnosis: _____

Description of treatment or procedure:
_____

ASSESSMENT DETERMINING RETURN FROM MEDICAL LEAVE:

Is this student's condition primarily related to:__ mental health __physical health __both_____
other _____

Is the student able to perform the following functions needed to return? Please provide comments below.

Activities of daily living:
Bathing or Hygiene ___Yes, independently ____ Yes, with recommended accommodation ____ No
Comment:_____

Eating and Nourishing Oneself ___Yes, independently ____ Yes, with recommended accommodation ____ No
Comment:_____

Medication Management and adhering to other care plan elements i.e. appointments
___Yes, independently ____ Yes, with recommended accommodation ____ No
Comment:_____

Ability to seek support and maintain safety ___ Yes, independently ____
Yes, with recommended accommodation ____ No
Comment:_____

Executive Functioning ___ Yes, independently ____ Yes, with recommended accommodation ____ No
Comment:_____

Ability to attend full time enrollment schedule (12+ hours) ___Yes, independently
___Yes, with recommended accommodation ____ No
Comment:_____

Ability to engage with community ___Yes, independently
___Yes, with recommended accommodation ____ No
Comment:_____

Your overall recommendation regarding the student's readiness to return to academic enrollment:

__Student **is ready** to resume academic enrollment, and the rigor associated with being a full-time student while maintaining their care plan.

__Student **is not yet ready** to resume academic enrollment, and the rigor associated with being a full-time student while maintaining their care plan.

Any further comments:

PART 3: PLAN OF CARE UPON RETURN TO EMORY UNIVERSITY:

Student Case Management and Intervention Services will be involved with each student to assist with case management and connecting students to the resources needed to support their health, wellbeing, and academic success.

Please delineate the plan of care you are recommending for the student upon their return.

1. In this case, the student has completed their plan of care and is able to return with no further follow up or care (i.e., student who had mono or had a surgery). ___Yes ____No

OR, the student requires follow up care delineated below:

2. Will you continue to provide services for this student after they return to school? __Yes __No
3. What type of provider is necessary for follow-up care (check all that apply)?(indicate frequency and name and contact information if available)
    a. Primary Care __yes __no
    b. Psychiatry __yes__no
    c. Counseling __yes __no
    d. Physical therapy __yes__no
    e. Surgery __yes__no
    f. Other Specialty, please specify _____
    g. Other required support:
    _____

    Have you discussed these recommendations with the student? __ Yes __No

    Is the student in agreement with these recommendations __Yes __No

4. Is the student currently taking medications? __yes __no
    Current Medications (if applicable):

Medication	Date Started	Dose/Frequency	Stable
			__Yes __No
			__Yes __No
			__Yes __No

5. Does the student require assistance with referrals (check all that apply)?:
    a. Primary Care___yes __no__
    b. Psychiatry __yes__no ____
    c. Counseling __yes __no _____
    d. Department of Accessibility Services for accommodations: __yes __no

6. Additional comments (optional):

___(Provider's Initials): I understand that Student Case Management and Intervention Services at Emory University or the clinical teams at Counseling and Psychological Services or Student Health Services may contact me to verify the information provided or if clarity is needed regarding their current treatment or recommendations for their level of care once the student returns. I also verify that I am not related to the student in any capacity.

Please sign below to confirm that all the information represented above is complete and accurate.

Provider Signature: _____ Date: _____

Provider Print: _____

Address:_____

Please complete in full and email to medicalrecords-shs@emory.edu. For further information regarding the medical leave process or concerns, please email medicalrecords-shs@emory.edu.