Wellness Area
University of San Diego
5998 Alcalá Park, Serra Hall 300
San Diego, CA 92110
619-260-4655 Fax: 619-260-4699

Community Provider Report Form

This form must be received at least 30 days before the beginning of a semester

NOTE: This form is to be completed by the student's community clinician/service provider and mailed, faxed or e-mailed by the provider directly to the following address:

University of San Diego
Wellness Area
5998 Alcalá Park, Serra Hall 300
San Diego, CA 92110
Fax: 619-260-4699
Wellness@sandiego.edu

Clinician Name________________________________
Licensed as___________________________________
License # ____________________________________
State of Licensure ____________________________

Student Name ______________________________________
Date of First Session _______________________________
Date of Most recent Session _________________________
Total # of Treatment Sessions ________________________

Initial Diagnosis____

Current Diagnosis____

Please provide your professional judgment in response to the following questions regarding the student named above.

1. ____Yes ____No Has there been a substantial amelioration of the student's original medical/psychological condition?

   If yes, please check all of the following that you have observed a marked reduction of in this student:
   ___Number of symptoms
   ___Severity of symptoms
   ___Persistence of symptoms
   ___Functional impairment
   ___Subjective level of client distress

2. ____Yes ____No Once achieved, has the substantially improved condition been maintained stably for two consecutive months?

Please explain ____
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____
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3. If applicable, has there been a substantial reduction of any of the following safety related behaviors the student may have been engaging in?

___Yes ___No ___N/A Suicidal behaviors
___Yes ___No ___N/A Self injury behaviors

___Yes ___No ___N/A Substance abuse behaviors
___Yes ___No ___N/A Failure to maintain weight at minimum of 90% of Ideal Body Weight for height
___Yes ___No ___N/A Food binging
___Yes ___No ___N/A Food purging or any other potentially harmful compensatory behaviors used for weight management (e.g., use of laxatives, excessive exercise, etc.)
___Yes ___No ___N/A Other: ____

___Yes ___No ___N/A Once achieved, has the substantial reduction in safety related behaviors been maintained stably for two consecutive months?

Please explain ____

4. ____Yes ____No In your opinion, is the student able to function safely, stably, and successfully as a full time university student at this time?

Please explain ____

5. ____Yes ____No If applicable, in your opinion, is the student able to live in the Residence Halls safely, stably and successfully at this time?

Please explain ____

6. ____Yes ____No Do you plan to continue to provide treatment if the student is reinstated at USD?

Please explain ____

If "No", what recommendations for treatment do you have for this student and what steps have been taken to secure this treatment?

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______________________________ ______________________
Clinician Signature Date