Habif Health and Wellness Center
STUDENT AFFAIRS AT WASHINGTON UNIVERSITY

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) 696-1215, 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

☐Attention / Concentration Impairment
☐Auditory Difficulty
☐Eating Disorder
☐Homicidal Ideation/Intent
☐Interpersonal Difficulties (Axis II related problems)
☐Motivational Difficulties
☐Mood Instability
☐Neurovegetative Depressive Symptoms
☐Obsessions/Compulsions
☐Panic Symptoms
☐Other: _____

☐Physical Impairment
☐Post-Traumatic Stress Symptoms
☐Psychotic Symptoms
☐Relationship Violence
☐Self-Injurious Behavior
☐Sleep Disturbance
☐Social Phobia Symptoms
☐Substance Abuse/Dependence
☐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	☐	☐	☐	☐	
Reading	☐	☐	☐	☐	
Writing	☐	☐	☐	☐	
Ability to attend class	☐	☐	☐	☐	
Test taking	☐	☐	☐	☐	
Other	☐	☐	☐	☐	

Current Risk Assessment

	Mild	Moderate	Severe	N/A	Unable to Assess	Comments
Risk of Medical Instability	☐	☐	☐	☐	☐	
Suicide Risk	☐	☐	☐	☐	☐	
Violence Risk	☐	☐	☐	☐	☐	
Self-Injury Risk	☐	☐	☐	☐	☐	
Other	☐	☐	☐	☐	☐	

Additional Comments:	

Treatment Modalities (Check all that apply)

Medication	☐ previous	☐ current	☐ recommended
Individual therapy	☐ previous	☐ current	☐ recommended
Group therapy	☐ previous	☐ current	☐ recommended
Residential/ inpatient treatment	☐ previous	☐ current	☐ recommended
	Type, provider and dates:	Type and provider:	Type and provider:
Outpatient treatment	☐ previous	☐ current	☐ recommended
	Type, provider and dates:	Type and provider:	Type and provider:
Hospitalization	☐ previous	☐ current	☐ recommended
	Type, provider and dates:	Type and provider:	Type and provider:
Nutritional therapy	☐ previous	☐ current	☐ recommended
	Type, provider and dates:	Type and provider:	Type and provider:
Physical therapy	☐ previous	☐ current	☐ recommended
	Type, provider and dates:	Type and provider:	Type and provider:
Surgeries/ procedures	☐ previous	☐ current	☐ 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:

Last Name, First Name: _____

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