Student name:

Health Information/Readiness for Return Form

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. When you are finished be sure to save the file before closing. Upon completion, fax this form to the Health Leave Case Manager and Washington University MLOA Committee at (314) 970-9093, or email to studentmedleave@wustl.edu with the understanding that email is not necessarily a secure method of communication. Thank you for your assistance.

The student and the provider should have a shared understanding of the information being submitted to the university on the student's behalf. Please note, a completed Health Information/Readiness for Return Form (HIRRF) must be received from each treating professional providing care while away. **This completed form must be received directly from the Healthcare Provider no earlier/later than four weeks prior to the student's requested re-entry date to the University.** Failure to complete this form will preclude the MLOA Committee from rendering a recommendation**.** If providers have questions or concerns a member of the Medical Leave Team can be reached via the below contacts.

Email: studentmedleave@wustl.edu
Phone: 314-935-5956
Fax 314-970-9093

The receiver of this documentation is a mandatory reporter to the University's Title IX process. Please be aware that any information that is disclosed surrounding physical and/or sexual abuse will be reported to the necessary agencies. This documentation will be shared with the Washington University MLOA Committee.

Treating Provider Medical Leave Reinstatement Questions:

Providers, please fully complete this form addressing the student's readiness to return. The MLOA committee relies heavily on your recommendations in order for your client/patient to have a successful return. Please include detailed recommendations should your client/patient be reinstated. Without this form fully completed the MLOA Committee will be unable to recommend reinstatement for the student.

Please use this checklist to verify all information is included.

☐ Student's name
☐ Student's diagnosis (if applicable)
☐ Treatment summary
☐ Detailed recommendations for student's successful return
☐ Your professional credentials and license number

Student name:

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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:
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 and treatment student has received for the eating disorder (with explanation of severity of behaviors); Please list all providers on the team treating the student for their eating disorder in the box noted below.**
- **Report of physical exam; Height and weight parameters for the last 3-6 months (depending on duration of leave); vital signs for the last 30 days**

Treatment Dates and Frequency with this Provider

Date of First Appointment: _____ Date of Most Recent Appointment: _____

Number of Appointments: _____ Frequency (weekly, biweekly, monthly)

If the student is receiving treatment from any other providers, please indicate

Provider(s) Name:	**Phone:**

Student name:

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Please provide your professional judgement to respond the following questions regarding the student named above.			
Did the focus of the patient's treatment sufficiently address the reasons for withdrawal.			
Has the student been compliant with all treatment (e.g. attended sessions, took medications, as directed, etc.)?			
Has there been substantial amelioration of the student's health /psychological condition? **If yes,** please check all of the following that you have observed a marked reduction in this student: ☐ Number of symptoms ☐ Severity of symptoms ☐ Persistence of symptoms ☐ Functional Impairment ☐ Subjective level of patient distress			
Has there been a substantial reduction of any of the following safety-related behaviors, which may disrupt the university environment, in which the student may have been engaging?			
Safety Related Behaviors			
Suicidal ideation			
Suicidal behaviors			
Self-injury behaviors			
Do you consider the student a threat to themselves or others? If so, please explain in free text box below			
Has the student failed to maintain at least 85% of their ideal body weight for their height? *if advocating for return at less than 85% IBW, please explain in free text box below			
Food bingeing			
Food restricting			
Food purging or any other potentially harmful compensatory behaviors used for weight management (use of laxatives, diuretics, rumination, excessive exercise, e.g., more than one hour per day).			
Behaviors that threaten others (e.g., violence, stalking), If yes, please explain in the free text box below.			
Has the student's use of alcohol or illegal drugs complicated treatment? If yes, please explain in free text box below.			
Others (please specify)			

Student name:

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Please elaborate on your answers below:

Any additional information you feel is relevant to student's possible return to school:

Student name:

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Treatment Modalities (check all that apply)

Medication	☐ previous	☐ current	☐ recommended	☐ completed
Individual Therapy	☐ previous	☐ current	☐ recommended	☐ completed
Group Therapy	☐ previous	☐ current	☐ recommended	☐ completed
Residential/ In-patient treatment	☐ previous	☐ current	☐ recommended	☐ completed
Outpatient treatment	☐ previous	☐ current	☐ recommended	☐ completed
Hospitalization(s)	☐ previous	☐ current	☐ recommended	☐ completed
Nutritional Therapy	☐ previous	☐ current	☐ recommended	☐ completed
PT/OT	☐ previous	☐ current	☐ recommended	☐ completed
Surgeries/ procedures	☐ previous	☐ current	☐ recommended	☐ completed
Other:				

Student name:

Health Information/Readiness for Return Form

Please check the following activities of which you believe the student is presently capable:

☐ Attend a lecture of up to 3 hours in length.
☐ Spend hours in study, maintain concentration, and grasp complex material
☐ Organize and write papers.
☐ Balance academic demands with extracurricular activities
☐ Manage social relationships.
☐ Manage daily living skills (hygiene, adherence to medication regimen, share community living space, respect for reasonable needs of others) so as to live independently in residential housing.
☐ Manage behaviors such as self-regulation, calming self
☐ Stand for periods of 30 minutes or longer
☐ Stand up from sitting down without significant dizziness or presyncope.
☐ Move around their home.
☐ Walk distances of at least a kilometer (or equivalent)
☐ Student has a diagnosed disability that could/is interfering with their functioning and would benefit from disability accommodations (academics, housing, transportation, etc…). *If yes, please review and complete the Disability Resource document for support.*
☐ Student is capable of carrying the required full academic course load (12-19 credits) at an academically rigorous institution. Noting, there is not a part-time option available to WU students.

During the student's leave from WU, has she/he/they demonstrated the ability to function autonomously in a job, volunteer position, college course, or other position which is supervised and evaluated or graded? ☐**Yes** ☐**No** ☐**Unsure**

If Yes, *please describe indicative behaviors you have observed that support your recommendation of reinstatement.*

To your knowledge, are the parents and/or legal guardian of the student aware of the problem(s) for which you have provided treatment? ☐**Yes** ☐**No** ☐**N/A**

If you have any additional information, comments, or concerns which you believe should be considered in deciding on the student's application to return to WU, please attach these as needed.

Student name:

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Provider Attestation

In consideration of all of the information provided in this document, check and complete all that apply.

☐ I believe that this student ***IS medically stable and therefore ABLE*** to return to Washington University as a student.

☐ I believe that this student ***IS NOT medically stable and therefore NOT ABLE*** to return to Washington University as a student.

☐ I believe that this student ***IS psychologically stable and therefore ABLE*** to return to Washington as a student.

☐ I believe that this student ***IS NOT psychologically stable and therefore 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: _____

Please note, documentation with missing information from providers will result in the documentation being deemed not sufficient for review of student's return.