Bryn Mawr College Re-Enrollment Assessment Form for Health Care Providers

To my treatment provider,

I am currently on a medical or psychological leave of absence from Bryn Mawr College. I left Bryn Mawr on _______________ (month / date / year) in order to engage in appropriate treatment, resolve the issues that led to my leave of absence, and solidify the coping skills I will need to succeed and flourish upon my return to a residential academic community and to a rigorous full-time course of study.

Bryn Mawr has two re-enrollment cycles, one for students applying to return in the fall with a deadline of May 1, and another for students applying to return in the spring with a deadline of November 1. I am now applying for permission to return to Bryn Mawr and my application is due on ___________ (date / month / year). As part of my re-enrollment application, I am asking you to complete this form as thoroughly and truthfully as possible and send it to the re-enrollment committee so that they may evaluate my readiness to return.

Sincerely,

_______________________________________________            ____________________________________________________                    __________________________
Student signature    Student name printed                        Date

To the treatment provider,

Thank you for your help in our evaluation process. We are asking for 1) information about your work with the student, 2) the progress the student has made, 3) your opinion about whether the student is healthy enough to resume studies and residence at Bryn Mawr College for the upcoming semester, and 4) your recommendations for continuing supports should the student be allowed to return.

Please complete the attached form and return it to the student for confidential submission into their student electronic health record.

Sincerely,

Judy Balthazar, Dean of Studies and convener of the Re-Enrollment Committee
Bryn Mawr College Re-Enrollment Assessment Form for Health Care Providers

Student’s Name:_____________________________________ Date of Birth:________________________

1) **Information about your work with the student:**

**Initial Diagnoses:**

______________________________________  **Current Diagnoses**

______________________________________  ______________________________________

Has the student has been in the hospital, PHP, IOP or a treatment program? Yes / no  If yes, please attach initial evaluation and discharge summaries.

Please indicate all forms of treatment that apply to your contact with the student (check all that apply):

**Behavioral Health Care**  **Medical Care**

___ Individual therapy  ___ Ongoing medical treatment
___ Group therapy  ___ Physical therapy
___ Individual nutrition counseling  ___ Hospitalization
___ IOP  ___ Surgery
___ Day treatment  ___ Laboratory studies
___ Partial hospitalization program  ___ Other: ____________________________
___ Residential program
___ Substance abuse treatment program
___ Other: ____________________________

Please indicate the duration of any behavioral health treatment:

If individual or group treatment, please indicate

_____ date of the first visit after the leave began  _____ name of the program
_____ the date of the most recent visit  _____ date of admission
_____ total number of visits  _____ date of discharge

Has the student terminated treatment with you or your program? yes / no

If yes, was the termination mutual and planned? yes / no

If yes, please describe the discharge plan. If no, please explain further

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________
2) **Assessment:**

Have you observed substantial amelioration of the student’s health/psychological condition?  yes / no

If yes, check all of the following in which you have observed a marked improvement in this student:

- Number of symptoms
- Functional impairment
- Severity of symptoms
- Subjective level of distress
- Persistence of symptoms

Has there been a substantial reduction in any of the following behaviors the student may have been engaging in?

- Suicidal behaviors
- Self-injury
- Substance abuse
- Failure to maintain ideal body weight for height
- Food binging
- Food purging or any other potentially harmful compensatory behaviors used for weight management (use of laxatives, excessive exercise, etc.)
- Other: ________________________________________

Has this substantial improvement been maintained?  yes / no.  If so, for how many months? _____

Please elaborate:

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
3) **Recommendation regarding return at this time:**

In your professional judgment, is the student healthy enough to return to Bryn Mawr’s residential academic community and its rigorous full-time course of study for the upcoming semester? What do you see as the pros and cons of the student returning at this time?

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

4) **Recommendations regarding treatment upon return**

If you recommend that the student return for the upcoming semester, what are your recommendations for continuing support and care once the student has returned to Bryn Mawr?

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Additional information: __________________________

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Name __________________________________________ Address ____________________________________________

Phone Number __________________________ Email address

Professional license ___________________________ License number and state________________________

Signature ___________________________ date __________________________