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 submit it to

Bryn Mawr College Health Center
101 N. Merion Ave.
Bryn Mawr, PA 19010
Fax: 610-526-7365

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  

___ Individual therapy  
___ Group therapy  
___ Individual nutrition counseling  
___ IOP  
___ Day treatment  
___ Partial hospitalization program  
___ Residential program  
___ Substance abuse treatment program  
___ Other: ____________________________________

Medical Care  

___ Ongoing medical treatment  
___ Physical therapy  
___ Hospitalization  
___ Surgery  
___ Laboratory studies  
___ 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  
________ the date of the most recent visit  
________ total number of visits  

If treatment program, please indicate  

________ name of the program  
________ date of admission  
________ 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 potential 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 __________________________________________