Students of Concern Assistance Team
University of South Florida
4202 East Fowler Avenue, SVC 2129
Tampa, Florida 33620
Phone: 813-974-6130 (fax) 813-905-9985
Email: socat@usf.edu

USF STUDENT AFFAIRS
UNIVERSITY OF SOUTH FLORIDA

Community Provider Report Form

INSTRUCTIONS TO THE COMMUNITY PROVIDER:
On occasion, a student may take a health-related withdrawal from the university, be it voluntary or involuntary. For the welfare of the student, the University of South Florida & its Students of Concern Assistance Team (SOCAT) seeks to encourage that students demonstrate readiness to return to the college with the capacity and supports in place to manage the rigors of academia. Therefore, it is the request of the University of South Florida that any student seeking return to classes after a Health-Related Withdrawal from this institution have this 3-page form completed by a licensed health professional. It should be submitted 30 days before the start of the semester for which the student intends to return.

NOTE: This form is to be completed by the student's community provider/mental health clinician and mailed or faxed to Student Affairs Case Management Services at the address or number listed above. If mailed, please include the following caption clearly on the outside of the envelope: "To Be Opened By Addressee Only."

If this student believes they are entitled to accommodations and wishes to document a disability, they should contact Students with Disabilities Services, 813-974-4309. Information can be found on their website: http://www.sds.usf.edu/

Provider Name:	Student's Name: Student ID # (if available):	
Provider's Professional Credentials:	License #:	State of Licensure:
Date of Completed Assessment:	Total # of Sessions:	
DSM Axis I Diagnosis:	GAF: (initial) (end of treatment)	
Student's reason(s) for seeking mental health care:		
Current treatment regime; including medications:		

Please provide your professional judgment to respond to the following questions regarding the student named above. Please include comments where indicated.

Comments on student's **current functioning**:

Is the student named above **currently exhibiting** any of the following behaviors?

☐ Yes ☐ No ☐ NA	Suicidal ideation and behaviors
☐ Yes ☐ No ☐ NA	Self injury behaviors
☐ Yes ☐ No ☐ NA	Threats/aggressive behaviors
☐ Yes ☐ No ☐ NA	Substance abuse behaviors
☐ Yes ☐ No ☐ NA	Food binging
☐ Yes ☐ No ☐ NA	Failure to maintain weight at minimum of 90% of Ideal Body Weight for height
☐ Yes ☐ No ☐ NA	Food purging or any other potentially harmful compensatory behaviors used for weight management (e.g., use of laxatives, excessive exercise, etc.)
☐ Yes ☐ No ☐ NA	Other behaviors related to the safety of the student or others: If applicable, **please specify behaviors:**
If yes to any of the above, please include **comments:**	

☐ Yes ☐ No ☐ NA	Is student able to function safely and autonomously, without supervision, in a campus academic environment? **Comments:**
☐ Yes ☐ No ☐ NA	Is student able to function safely and autonomously, without supervision, in a campus residential facility? **Comments**:
☐ Yes ☐ No ☐ NA	Do you think this client is capable of carrying a full academic load (12-19 credit hours) at a University? Please indicate if you believe that a course reduction is recommended or if specific types of course should not be attempted at this time.
☐ Yes ☐ No ☐ NA	Is follow up and/or after care treatment recommended? If yes, **please specify type(s) of recommended treatment**:
☐ Yes ☐ No ☐ NA	If you have referred the client for continuing treatment, do you believe he/she would be able to function appropriately as a student at a University without that continued treatment?

☐ Yes ☐ No ☐ NA	Can after-care realistically be received utilizing campus or community resources?
Please keep in mind that the University of South Florida's Counseling Center is a SHORT–TERM, solution-based center, and that a referral to the service for long-term psychotherapy is inappropriate for the student. Students needing long-term psychotherapy are referred to a community mental health professional. Students are responsible for providing their own transportation to these appointments and are required to confirm proof of treatment through informed consent between the community provider and SOCAT program staff.	
☐ Yes ☐ No ☐ NA	If the student is approved to remain enrolled at the College, should stipulations be placed on enrollment (e.g. continued treatment, AA/NA, periodic drug testing, etc.)? If yes, **please specify recommended stipulation(s):**

Additional comments (optional):
If you wish to expand on your responses to the questions above and/or to record any other comments or observations you may wish to make regarding the student and his/her ability to function safely, stably, and successfully as a student, please use additional pages or attach additional documentation.

ATTESTATION BY COMMUNITY PROVIDER:

By signing where indicated below I am representing to the University of South Florida that my response to each question listed above is true, complete, and accurate to the best of my knowledge and belief, that it constitutes my best professional judgment and opinion, and that the Patient did not prepare or draft that response for my signature.

x _____ Date: _____
(Legal Signature)

Printed Name and Professional Status: _____

Address: _____

Phone: _____ FAX: _____ Email: _____