COLLEGE of CHARLESTON

OFFICE OF THE DEAN OF STUDENTS

Division of Student Affairs
66 George Street
Stern Center 3rd Floor
Charleston, SC 29424
Phone: 843.953.5522
Fax: 843.953.5403

Treatment Provider Report Form
for Student Mental Health Assessment

INSTRUCTIONS TO THE TREATMENT PROVIDER: The student (patient/client) named below is a student of the College of Charleston who, due to behavior that appeared to put them at risk, has been required by this office to complete a mental health assessment by a designated date. The student should have provided you with a copy of that Notification Letter that includes the designated completion date. As per College policy, timely completion of this assessment is a condition of this student's continued enrollment and, if applicable, continued residence at the College of Charleston. The College will weigh your opinion when assessing the student's ability to function safely and autonomously in this environment, meet the essential elements of his/her intended academic program of instruction and adhere to the College's Code of Conduct.

NOTE: This form is to be completed by the student's treatment provider/mental health clinician and submitted to the Dean of Students Office at the address or number listed above. If FAXED, please call first. If mailed, please include the following caption clearly on the outside of the envelope: "To Be Opened By Addressee Only." For on-campus providers, this form may be returned via email. Please call 843-953-6088 for the appropriate email address.

If this patient believes they are entitled to accommodations and wishes to document a disability, they should contact the Center for Disability Services 843-953-1431. Website: http://www.cofc.edu/~cds/

☐ **I have read the attached Notification Letter from the College that was provided to me by the patient.**

Provider/Clinician Name:	Patient/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:	
Student's reason(s) for assessment:		

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	Is follow up and/or after care treatment recommended? If yes, **please specify type(s) of recommended treatment:**
☐ Yes ☐ No ☐ NA	Can after-care realistically be received utilizing campus or community resources? **Comments:**
☐ 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 College of Charleston 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. Legal Signature: ____ Date: ____ Printed Name & Professional Status: ____ Address*: ____ * for on-campus providers, "CASAS" is sufficient Phone: ____ FAX: ____ Email: ____
Form Revised 10/8/10