COMMUNITY PROVIDER REPORT

Must be completed by the student's community mental health clinician/service provider and mailed by the provider directly to:

Wellness Center
Attention: MLOA
Loyola University Chicago
6439 N Sheridan Road, Suite 310
Chicago, Illinois 60626
Phone: (773) 508-2546 • Fax: (773) 508-2242

Clinician Name _____ Student Name _____
Licensed as _____ Date of First Session _____
License # _____ Date of Most Recent Session _____
State of Licensure _____ Total # of Treatment Sessions _____
Initial DSM Axis I Diagnosis _____ Initial Axis II Diagnosis _____
Current DSM Axis I Diagnosis _____ Current Axis II Diagnosis _____
GAF upon initial session (DSM Axis V) _____GAF at last session (Axis V) _____

Medications: (include dose, length of time on medication and length of time student has been stabilized on current dose)_____
_____
_____
_____
_____

Please provide your professional judgment in response to the following questions regarding the student named above.

___Yes ___No Has there been a substantial amelioration of the student's original medical/psychological condition?

If yes, please check all of the following that you have observed a marked reduction of in this student:

___ Number of symptoms ___ Severity of symptoms ___ Persistence of symptoms
___ Functional impairment ___ Subjective level of client distress

___Yes ___No Once achieved, has the substantially improved condition been maintained stably for three consecutive months?

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

___Yes ___No ___N/A Suicidal behaviors
___Yes ___No ___N/A Self-injury behaviors
___Yes ___No ___N/A Substance abuse behaviors
___Yes ___No ___N/A Failure to maintain weight at minimum of 90% of Ideal Body Weight for height
___Yes ___No ___N/A Food binging
___Yes ___No ___N/A Food purging or any other potentially harmful compensatory behaviors used for weight management (e.g., use of laxatives, excessive exercise, etc.)
___Yes ___No ___N/A Other:
___Yes ___No Once achieved, has the substantial reduction in safety related behaviors been maintained stably for three consecutive months?

___ Yes ___No Has the student followed all treatment recommendations?

[over]

Additional comments:_____
_____
_____
_____

Please provide a brief narrative indicating the degree to which issues have been resolved and the student's ability to function safely, stably, and successfully as a full-time university student at this time.

Please make recommendations for continued care and specifically address the following areas:

Mental Health Treatment:_____
_____
_____
_____

Will the student continue treatment with you? ____Yes ____No, if not please provide the name and contact information to whom the student was referred.

_____

Academics:_____
_____
_____

Ability to live independently and participate in residential life in a residence hall:_____
_____
_____

Social Skills:

_____
_____
_____

Potential concerns:

_____
_____
_____

_____ _____

Clinician Signature Date

Clinician's address telephone email:

_____