Health Provider Report Form
Health Center

514 University Ave.
Susquehanna University
Selinsgrove, PA 17870
570-372-4385 - Fax 570-372-2729

NOTE: This form is to be completed by the student's health care provider and mailed by the provider directly to the Health Center at the address indicated above. This form must be received no later than two weeks prior to a planned return.

Clinician Name: Clinician Phone #:	Student Name:
Licensed as:	Date of First Visit:
License #:	Date of Most recent visit:
State of Licensure:	Total # of visits:
Diagnosis:	
Current assessment:	

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 condition?

If yes, please check all of the following markers of substantial amelioration:

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

___Yes ___No Once achieved, the substantially improved condition has been maintained stably for _____ days/weeks/months (circle one).

What are your recommendations for further treatment, if any?

What recommendations have you discussed with the student regarding strategies for prevention of relapse or recurrence of similar problems?

What restrictions, if any, (e.g. living abroad, sports participation, dietary, housing) apply to this student at this time?

_____ _____

Clinician Signature Date

Thank you for your time in completing this report. If you have any questions, please contact the Health Center at 570-372-4385. Please feel free to attach additional information, on letterhead. Please attach any discharge summary, as appropriate.

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