Mental Health Provider Report Form
Counseling Center
514 University Ave.
Susquehanna University
Selinsgrove, PA 17870
570-372-4751 Fax 570-372-2776

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

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 Diagnosis	GAF score at start of treatment:
Current DSM Diagnosis	Current GAF score:

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 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).

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 ideation
___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 or restricting
___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 Behaviors that threaten others (e.g. violence, stalking)
___Yes ___No ___N/A Other:

___Yes ___No Once achieved, the substantial reduction in the above behaviors 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?

Do you have any additional information regarding the ability of this student to function safely, stably, and successfully as a full-time university student in a residential setting?

Please attach a summary of treatment and a discharge summary (if treatment was provided at a hospital).

_____ _____

Clinician Signature Date

Thank you for your time in completing this report. If you have any questions, please contact the Counseling Center at 570-372-4751.

Dr. Stacey Pearson-Wharton
Interim Director, Counseling Center