Name:____**D.O.B.**________________

Request for Documentation & Medical Re-entry Form

Instructions:

This form is to be completed by one of these licensed professionals:

- **Psychological needs -- Licensed LCSW, LMHC, LPC, PH P, or equivalent mental health professional**
- **Physiological needs -- Licensed MD, PA, NP, or specialist where applicable**

Please be as detailed and specific as possible. Your report will serve as the basis for our decision. This form must reflect the specific and thorough treatment received by the requester by the licensed professional completing this form. Ensure that any information provided is complete and legible. Leave nothing blank. Incomplete forms will not be considered.
Feel free to attach additional pages or documentation as needed.

Completed forms:

- **Fax the completed form.**
- **Post** hard copy afterwards.

Medical, Academic, & Psychiatric Committee
Roxanne McCarty, Chair
Center for Accommodative Services
7833 State Route 30 – P.O. Box 265
Paul Smiths, NY 12970
e: rmccarty@paulsmiths.edu
p: (518) 327-6414 f: (518) 327-6369

Name:____**D.O.B.**_________________

DIAGNOSIS

□ Mental Health DSM 5 Diagnosis
Date of Diagnosis: ___________

Primary: ____________________
Secondary:___________________
Tertiary:_____________________

□ Physical Health Diagnosis
Date of Diagnosis: _________

____
____
____

Prognosis of Condition: □ □ Permanent □ Temporary Time Frame: ___________________________

Treatment Start Date: ________________ Total #Visits:________________

Has the above-named student completed treatment?
□ Yes Treatment End Date: __________
□ No Date of Last Contact with Student: _____________

Have you referred the student for continuing treatment? □ Yes □ No
If yes, provide contact information of the individual or agency:
Name: ____
Address: ____
Phone: ________________________Fax: _____________________________
E-mail: ____

Indicate the type of treatment. ____

____

____

You may wish to consult with Counseling and/or Health Services personnel regarding the availability and appropriateness of referral resources in the community. In the case of psychological concerns, please keep in mind that the ***Paul Smith's College Student Counseling Center is a SHORT-TERM, solution-based center, and that a referral to it for long term intensive psychotherapy is inappropriate for the student.***

Diagnostic tools/instruments/procedures used to determine condition: _____________________________

____

____

Name:____**D.O.B.**_________________

Briefly describe the student's condition. Attach a separate page if necessary.

____

____

____

Does the student require medication in order to function effectively? ☐ Yes ☐ No
List medications and dosage:

____

____

____

Do you consider the student to be a threat to his/her own life or the lives of others? ☐ Yes ☐ No
Comment: ____

____

Does the student have any restrictions or limitations? ☐ ☐ Yes ☐ No
Describe them. ____

____

____

Recommended **academic** accommodations:

- ☐ Note taking assistance
- ☐ Testing modifications
- ☐ Adjusted course load (normal load is 15-18 hours)
- ☐ No outdoor labs or other physical academic accommodations
- ☐ Other ______________________________________
- ☐ Not Applicable

Provide reasoning/details: ____

____

____

Name:____**D.O.B.**_________________

Recommended **environmental** accommodations:

- ☐ Living conditions
- ☐ Classroom modifications
- ☐ Food
- ☐ Parking
- ☐ Off campus living at home or in the community
- ☐ Single room
- ☐ Other ________________________________
- ☐ Not Applicable

Provide reasoning/details: ____

____

____

Treating Professional (PRINT LEGIBLY):

Name:____________________________________ Specialization:_______________________

Address: ________________________________ Degree/Credentials: __________________

________________________________ __________________________________

Phone #__________________________________ Fax #______________________________

License #________________________________ e-mail:____________________________

____

Signature of Licensed Professional Date

Answer questions below only for students requesting return from Medical Withdrawal

Do you recommend re-enrollment at Paul Smith's College at this time? (Do you think the student will be able to be academically successful given their current level of functioning? It is important to us that the student is well enough to fulfill their student role in the academic setting by attending classes and completing their academic work. Please remember students are not able to be personally supervised in the residence halls or in classes.) ☐ Yes ☐ No

Please elaborate. ____

____

____

Name:____D.O.B.__________________

____