**Community Mental Health Provider Report**

This form is to be completed by the student and their community medical and/or mental health provider and sent (mailed/faxed) by the provider directly to the Dean of students at the address listed at the end of this document. "Provider" means Licensed Healthcare Provider (e.g. MD, DO, Psychologist, Licensed Clinical Social Worker, Licensed Clinical Mental Health Counselor, etc.). **The singed form must be received by Saint Michael's College by July 1st for the fall semester, December 1st for the spring semester, and April 1st for the summer semester.**

**Student Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TO BE COMPLETED BY STUDENT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorize the clinical staff at the Bergeron Wellness Center to exchange information with

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider name and address

This authorization is for the purposes of coordination of my care. Any further discourse, copying, distribution or use of the contents of this information is prohibited.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Signature Date

**TO BE COMPLETED BY PROVIDER**

Clinical Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of first session\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of most recent session\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total # of sessions\_\_\_\_\_\_\_\_\_\_\_\_

Licensed as \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ License #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GAF score at start of treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GAF score at discharge\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If GAF is lower than 70, please describe the critical areas of diminished capacity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initial DSM Diagnostic Description\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current DSM Diagnostic Description\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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\_\_\_ Yes \_\_\_ No  **Has there been a significant improvements of the student's original medical/psychological condition?**

If yes, Please check all of the following that you have observed a significant improvement with this

student:

\_\_\_\_ Number of symptoms

\_\_\_\_ Severity of symptoms

\_\_\_\_ Persistence of symptoms

\_\_\_\_ Functional impairment

\_\_\_\_ Subjective level of client distress

\_\_\_ Yes \_\_\_ No **Has the substantially improved condition been maintained consistently for at least four consecutive months?**

If the answer is no, please elaborate below.

**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 and/or suicidal ideation

\_\_ Yes \_\_ No \_\_ N/A Self injurious behaviors

\_\_ Yes \_\_ No \_\_ N/A Substance abuse behaviors

\_\_ Yes \_\_ No \_\_ N/A Failure to maintain weight at minimum of 85% Ideal Body Weight for height

\_\_ Yes \_\_ No \_\_ N/A Food binging

\_\_ Yes \_\_ No \_\_ N/A Food purging or other potentially harmful compensatory behaviors used for weight management (e.g.

use of laxatives, excessive exercise,etc).

\_\_ Yes \_\_ No \_\_ N/A Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Yes \_\_ No \_\_ N/A Has the substantial reduction in safety related behaviors been maintained stably for at least four

consecutive months?

**What evidence has been demonstrated to suggest that the student has increased ability to manage stress and cope with life demands?**

**What responsibilities has the student maintained during their time away from the college that suggests he/she is ready to return to the rigors of academia and an instructed, unsupervised environment?**

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**Academic Enrollment Recommendations**

\_\_\_\_Client is ready to return to the instructed and demanding academic environment on a full time basis.

\_\_\_\_Client is not ready to resume full-time enrollment, but it is recommended that he/she enroll part time.

\_\_\_\_Client is not yet ready to resume any academic enrollment.

Comments:

**Discharge Information (**if applicable)

\_\_\_ Client initiated discharge \_\_\_\_\_ Provider initiated discharge

Please describe the plan for the client at time of discharge.

**Continued Treatment Recommendations**

\_\_\_\_ Continued treatment is **not** recommended at this time.

\_\_\_\_ Client will remain in treatment with this provider.

­\_\_\_\_ Treatment will be transitioned to another provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Using you clinical judgment, please use the space below to elaborate on the level of care you feel the student will need to be most successful when returning to Saint Michael's College. Please be aware that the services offered by Saint Michael's College are limited to short-term, out-patient counseling and psychiatry. If part of the treatment plan for the student to receive services at Saint Michael's College, please be advised that a consultation with our treatment team is required before we accept students into our care. Please contact Kathleen Butts, Director of Counseling Services, to initiate this contact.

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinical Signature Date

Please use the back of this page to attach additional documentation if you wish to expand your response 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 at this time.

**DO NOT RETURN THIS FORM TO THE STUDENT**

**Return form directly to:**

Kathleen Butts, MA, LCMHC, LADC

Director of Counseling, Bergeron Wellness Center

Saint Michael's College

Box 259 One Winooski Park

Colchester, Vermont 05439

Ph. 802.654.2310

Fax.802.654.2699

**Questions may be addressed to:**

Kathleen Butts

Director of Bergeron Wellness Center

[kbutts@smcvt.edu](mailto:kbutts@smcvt.edu)

Dawn Ellinwood

Vice President of Student Affairs

[dellinwood@smcvt.edu](mailto:dellinwood@smcvt.edu)

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