

PART A – To Be Completed and Signed by Individual

A1 LEAVE: I _____ am requesting a **Emergency Medical Withdrawal**. I agree to participate fully in the remainder of the process including meeting with off-campus Health Provider to complete Part B of this form within 15 days and arrangements to return home immediately (24 hours). I understand this will help determine my eligibility for leave and return, and failure to follow timelines, recommendations or submit sufficient documentation of post-treatment stability may result in an unsuccessful application for readmission.

or READMISSION: I _____ am requesting readmission for _____. I have supplied the provider with all information about my history of mental health and physical symptoms, or other related to my ability to function as a student. This form should be completed no less than 30 days prior to the start of classes. It is the applicant's responsibility to ensure the form is complete and received on time.

I voluntarily consent to the multi-directional release of information between the provider named below and the Peterson Counseling Center (PCC), and of both the provider and the PCC with the Ringling Registrar's office and VP for Student Affairs and/or their designee. This release is for the purpose of making decisions about my request for leave/return and coordinating care, and includes **entire medical record including all mental health records and records for alcohol and other drug treatment**. A release with more options and further details are available at <http://health.ringling.edu>. Paper or electronic copies of this authorization shall be sufficient authorization for the release of records. I release Ringling College, Ringling staff and their supervisor(s) from any liability arising from the release, miscommunication, or failure to release information, provided the release is done substantially in accordance with the law. I understand that I need not sign this consent form in order to receive services. The PCC makes no claims or guarantees about the handling of information by the parties above once released and I agree not to hold Ringling College, PCC, or its staff liable for any consequences that result from such disclosure or non-disclosure. Individuals receiving the information may be governed by different or less strict laws/guidelines regarding the release of information than the counseling center staff. I understand that I may revoke these permissions at any time in writing, except to the extent that the providers have already acted in reliance on it. Absent such prior withdrawal this consent will expire in one year from last contact. Please speak with PCC staff and other relevant parties before signing if you have any questions. Readmission is not guaranteed and I will contact Director of Advising, Records & Registration Mr. Justin Selph, <jselph@ringling.edu> or (941) 359-6116 to complete the readmit application. *By signing this release form, I acknowledge that I have read, understood and voluntarily made or granted aforementioned permission and requests.*

A2 Signature of Individual: _____ Date _____

PART B – Licensed Non-Family Health Provider | May attach additional documentation but a **letter may not substitute for completion of this form.**

Provider's Name: _____ Provider Phone: _____ Provider Fax: _____
 Licensed as _____ License # _____ License State _____

Patient's Name: _____ Patient Date of Birth ____/____/____
 Date of First Session ____/____/____ Most Recent Session ____/____/____ # of Sessions To-Date _____

- 1) Current Diagnosis: _____
 2) Diagnoses/Concerns for which individual is seeking or **initially** sought treatment: _____

Please provide your best professional judgment in response to the following questions:

- 3) ___ Yes ___ No Symptoms related to Diagnosis above are sufficient to prevent individual from functioning effectively as a student
 4) ___ Yes ___ No Symptoms are likely to resolve on their own without treatment
 5) Treatment recommendations include ___ Psychotherapy: (___ 1x/week ___ more than once a week ___ less than once a week)
 ___ Partial Hospitalization/day treatment ___ Inpatient including substance and ED recovery
 ___ Other:
 6) ___ Yes ___ No Individual has missed one or more appointment or failed to follow medical advice to best of your knowledge.

7) Is there evidence or reports of the following behaviors now or in the past two years?

Please mark "never reported" if individual did not evidence OR disclose a history of such behaviors at any point during treatment.

___ Yes	___ Yes, but reduced	___ No	___ Never reported	Physical impairment: _____
___ Yes	___ Yes, but reduced	___ No	___ Never reported	Suicidal behaviors
___ Yes	___ Yes, but reduced	___ No	___ Never reported	Self-injury, impulsivity, or other risky behaviors
___ Yes	___ Yes, but reduced	___ No	___ Never reported	Substance abuse behaviors
___ Yes	___ Yes, but reduced	___ No	___ Never reported	Failure to maintain weight at > 90% of Ideal Body Weight for height
___ Yes	___ Yes, but reduced	___ No	___ Never reported	Food binging, purging, other harmful behaviors for weight control
___ Yes	___ Yes, but reduced	___ No	___ Never reported	Thoughts, behaviors, or other related to harming others
___ Yes	___ Yes, but reduced	___ No	___ Never reported	Other: _____

If applying to return:

- 8) ___ Yes ___ No Student is at minimal or no risk for harm to self or others if he or she returns to a rigorous academic schedule beginning: ____/____/____ (day / month / year ONLY if "yes", able to return)
- 9) ___ Yes ___ No There has been a substantial amelioration of the individual's original medical conditions reported above sufficient to believe this individual can function successfully as a student.
- IF YES, for how long:
 ___ 0-1 month ___ 1-3 months ___ More than 3 months (may be required for return to campus) ___ 6+ months

Clinician Signature _____

Date _____