RINGLING COLLEGE OF ART AND DESIGN, ADVISING AND REGISTRATION
2700 N. Tamiami Trail, Sarasota, FL 34224 | (941)359-6116
Please return by **Fax (941) 359-6115** or scan to **registrar@ringling.edu**

12/04/2014

PROVIDER REPORT

Please have your provider complete **two copies**, first on **leave** & again 30 days prior to **re-admit**.

PART A – To Be Completed and Signed by Individual

A1 LEAVE: I _____ (print name) 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 _____ (print name) am requesting readmission for _____ (term/year). 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_____