Medical Clinic
Health & Counseling Services
Eastern Illinois University

600 Lincoln Avenue
Charleston, IL 61920-3099
Office: (217) 581-3013
Fax: (844) 256-6402

Health Evaluation Form for Medical Withdrawal Reinstatement

To the Health Care Provider: The student named below is requesting reinstatement to Eastern Illinois University after having taken a medical withdrawal. The information you provide on this form will be used to determine the student's readiness to resume academic study and/or independent living expected as a college student, often within on-campus residential or multi-occupant settings. Please provide as much detail as possible about the student's current level of functioning and their course of treatment during the period of the medical withdrawal.

Please be advised that students returning who require continued medical treatment must have a treatment plan in place at time of restatement. Students returning who require continued psychological or psychiatric care will be expected to have a treating provider in place at the time of reinstatement.

Upon Completion, please fax or mail this form (with the signed consent forms below) to:

Eastern Illinois University Health and Counseling Services
Attn: Eric S. Davidson, Executive Director, Ph.D., MCHES
600 Lincoln Avenue
Charleston, IL 61920
217-581-3013 (phone)
217-581-2010 (fax)

Identifying Information

Student Name:_____

Student ID #: _____Date of Evaluation:_____

Current treatment(s) (check all that apply and specify provider):

◯Medications: _____
◯Physical therapy:_____
◯Nutritional therapy:_____
◯Individual and/or group psychotherapy:_____
◯Substance abuse treatment:_____
◯Other:_____
_____

Current Medications (with dosages):

_____
_____

Prescribed by: _____

MEDICAL WITHDRAWAL DUE TO PSYCHIATRIC REASONS (please complete the following):

Diagnoses (please include ICD Codes)

Therapy/Treatment Description

Dates seen in therapy/treatment: ___/ _____/ _____to ____/ _____/ _____

Frequency of appointments: _____

Total number of sessions: _____

Treatment Goals:

Progress in Treatment (include any behaviors that hinder progress if applicable):

Current Clinical Impressions:

Prognosis: _____Good _____ Fair _____Poor

Probability of Relapse/ other concerns:

Current Risk Assessment:

	Low	Moderate	High	N/A	Unable to Assess	Comments
Suicide Risk						
Violence Risk						
Self-injury Risk						
Risk of medical instability						

PLEASE COMPLETE THIS SECTION FOR ALL WITHDRAWALS

Diagnoses (please include ICD Codes)

Therapy/Treatment Description

Dates seen in treatment/care: _____/ _____/ _____to ____/ _____/ _____

Treatment/Medical Interventions:

Frequency of appointments & Total number of sessions/appointments: _____

Level of Impairment (please describe):

Recommendations for Continued Treatment or Management of Illness/Injury:

PLEASE COMPLETE THIS SECTION FOR ALL WITHDRAWALS

Clinical Impressions and Recommendations

What amount of course work are you recommending that the patient return to:

____ Light – Part-Time (1-6 hours of Course Work)

____ Part-Time - Moderate (6-11 hours of Course Work for undergraduates, 6-8 hours for Graduate Students)

____ Full-Time (12 hours or More for Undergraduates, 9 hours or More for Graduates)

Why?

In your opinion, what ability level is the patient able to manage the stressors that present as part of the college experience?

	Low	Moderate	High	N/A	Unable to Assess	Comments
Academic						
Emotional						
Physical						
Relationships						
Residential						
Social						

Recommendations for continued treatment (check all that apply and specify provider and frequency):

◯Medical:

_____

◯Physical therapy:

_____

◯Medications:

_____

◯Nutritional therapy:

_____

◯Individual and/or group therapy:

_____

◯Substance Abuse Treatment:

_____

◯Other:

_____

PLEASE COMPLETE THIS SECTION FOR ALL WITHDRAWALS

If applicable, attach any other pertinent information, recommendations, or interventions that should be considered.

Attestation

Provider name:_____ Date:_____

Provider Practice Name and Address:

_____

_____

Provider Signature:_____

Provider Credentials: _____ License Number: _____

Telephone number:_____ Fax Number:_____