UNIVERSITY OF NOTRE DAME

University Counseling Center

Treatment Provider Readmission Questionnaire

Instructions: This form is to be completed only by a licensed mental health provider. Please respond to the questions listed below and **attach a brief statement of recommendation for readmission on your office letterhead**. Send the completed form and statement to the address indicated.

1. Full name of client: _____

2. Are you a _____ psychiatrist, _____ licensed psychologist, _____licensed social worker or _____licensed professional counselor?

   Did you provide the treatment for the above-named client?
   _____ Yes _____ No

3. Has the above-named client completed treatment? _____ Yes _____ No

4. When did the treatment commence? _____Conclude_____

5. Describe treatment: (include any hospitalization) _____

   _____

   _____

   _____

6. How many treatment sessions have you provided for the client (relating to this matter)?

   _____

7. Is the client presently on medication? _____ Yes _____ No
   Describe:

   _____

   _____

Student Readmission Questionnaire to Be Completed By Treating Agent

8. In your estimation, will client need to continue medication? ____ Yes _____ No

   Comments: _____

   _____

   _____

9. If the client has not completed treatment, how frequently will the client need to see you?

   _____

10. Have you referred the client for continuing treatment? _____Yes _____ No. If yes, please indicate the name, address, and phone number of the individual or agency. **Please keep in mind that the University Counseling Center operates under a brief therapy model. Students who seek treatment at UCC are presented to a Disposition team to determine the appropriateness of UCC services.**

    _____

    _____

    _____

11. Why have you referred the client for continuing treatment?

    _____

    _____

    _____

12. If you have referred the client for continuing treatment, do you believe he/she would be able to function appropriately as a student at the University of Notre Dame without that continued treatment?
    _____ Yes _____ No

13. Do you consider that the client presently, or in the reasonably foreseeable future, may be a threat to his/her own life or the lives of others? _____ Yes _____ No

    Comment:

    _____

    _____

    _____

14. Do you think this client is capable of carrying a full academic load (12-18 credit hours) at the University of Notre Dame? _____ Yes _____ No

15. To your knowledge, are the parents and/or legal guardian of the client aware of the problem(s) for which you have provided treatment? _____ Yes _____ No

16. Other comment:_____

_____

_____

_____

_____
Print Name of Treatment Provider

_____ _____
Signature of Treatment Provider Date

Please remember to attach a brief statement of recommendation for re-admission using your office letterhead. Return to: **Attention: Rita Donley, Ph.D., Associate Director, Readmissions, University Counseling Center, P.O. Box 709, University of Notre Dame, Notre Dame, Indiana, 46556-0709.**

A readmission application will not be accepted for review unless it includes this completed questionnaire and letter of recommendation submitted on your letterhead.

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This information is confidential and will be used as an aid to make a recommendation for readmission to the University of Notre Dame.