Treatment Provider Readmission Questionnaire

Instructions: This form is to be completed only by the treating physician, psychiatrist, licensed psychologist or licensed professional counselor. 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 _____ medical doctor, _____ 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:  
   ___________________________________________________________________
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.

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