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:

   ______________________________________________________________________

   ______________________________________________________________________
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: Amy Spanopoulous, LCSW, 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.

Revised 6/2019