UNIVERSITY OF NOTRE DAME
University Counseling Center

Treatment Provider Questionnaire

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

1. Full name of client: _____

2. Please indicate clinical licensure: _____

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

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

Treatment:

4. When did the treatment commence? _____ Conclude_____

5. Describe treatment: (check all that apply) :

☐ Inpatient hospitalization ☐ Residential treatment ☐ Partial Hospitalization

☐ Intensive Outpatient program ☐ Outpatient mental health counseling ☐ Psychiatry

_____

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

_____

7. List current medication and dose, including date of initiation:

_____

_____

P.O. Box 709. Notre Dame, Indiana 46556-0709. (574) 631-7336. FAX (574) 631-5643

https://ucc.nd.edu/

8. Do you recommend continued medication management? ____ Yes _____ No

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

_____

After-care Plan:

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.**

_____

_____

_____

11. Why have you referred the client for continuing treatment? What goals do you suggest for continued 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

List Date of most recent risk assessment and outcome of risk assessment. Include date of most recent in-patient hospitalization (if applicable).

_____

_____

_____

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 comments: _____

_____

_____

_____

_____

Print Name of Treatment Provider

_____ _____

Signature of Treatment Provider Date

Please remember to attach a brief statement of recommendation for return to the University using your letterhead. Return to: **University Counseling Center, Attention: Amy Spanopoulos, LCSW, Associate Director, Clinical Services, P.O. Box 709, University of Notre Dame, Notre Dame, Indiana, 46556-0709.**

An application to the University will not be accepted for review unless it includes this completed questionnaire and letter of recommendation submitted on letterhead.

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

Revised 9/21/2020