

HEALTH EVALUATION FORM

For
Medical Clearance When Applying for Readmission
University of California, Berkeley
(To be completed by medical provider)

Upon completion, **please mail or fax this form and a copy of your Release of Information directly to our office at:**
 University Health Services, Social Services Unit, 2222 Bancroft Way, room 2280, Berkeley, CA 94720, phone 510-642-6074, fax 510-643-0211.
 This is a confidential fax machine. **If this form is given to the student for hand delivery, please place in a sealed letterhead envelope with, and sign the outside seal.**

The student named below is applying to return to UC Berkeley following a medical leave. The information you provide will be used in helping reach a determination as to readiness. It will not become a part of the student's academic or health record, but will be retained in a separate administrative file.

TO BE COMPLETED BY STUDENT	
Student Name (Last, First, MI):	Date:
Student ID#:	DOB:
THE FOLLOWING INFORMATION SHOULD TO BE COMPLETED BY TREATING PROVIDER ONLY	
Diagnosis:	Date of Diagnosis:

UC Berkeley is a highly competitive academic institution. Many students find it highly stressful to succeed with the demanding course loads and expectations. In your professional opinion, do you believe the student is ready to return to U

Berkeley at this time? Yes No Unable to assess

If yes, please choose from the following:

- I believe the student is able to carry a full course load without accommodations.
- I believe the student is able to carry a full course load with accommodations.

Please comment: _____

Please consider a reduced course load for the following reasons: _____

Check below degree student's current condition might impede academic performance:

	No Impairment	Mild Impairment	Moderate Impairment	Significant Impairment	Severe Impairment
Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to attend class	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to multi-task	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to complete complex tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to follow through	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to work collaboratively w/peers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to self-motivate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Risk Assessment (Check those which currently apply):

Risk of medical instability Not at all Mild Moderate Severe Unable to assess

Risk of suicide: Not at all Mild Moderate Severe Unable to assess
Risk of violence: Not at all Mild Moderate Severe Unable to assess
Self-injurious behavior: Not at all Mild Moderate Severe Unable to assess

Treatment History (Check all that apply):

Psychiatric Substance abuse Medical Evaluation only

Outpatient treatment within: 6 months 1 year 2-5 years

Partial Hospitalization or Day Care within: 6 months 1 year 2-5 years

Residential Treatment within: 6 months 1 year 2-5 years

Inpatient Treatment (overnight admission)

within: 6 months 1 year 2-5 years

Surgery for present illness within: 6 months 1 year 2-5 years

For hospitalization stay, please include discharge summary with this form

Comment:

Treatment Modalities: (Check all that apply):

Individual Psychotherapy Group therapy Medication Pain management Bed rest Physical Therapy

Nutritional Therapy Other forms of treatment or community services being utilized: Yes No

If yes, please specify: _____

Treatment Progress: Beginning date: _____ How often seen: _____

of appointments to date: _____ # of appointments to complete treatment: _____

Is patient actively participating in treatment on a regular basis? Yes No

Current condition: Unstable Partially stable Stable (# of weeks _____) Date of last appt: _____

Daily activities impaired: Not at all Mildly Moderately Severely

Comment:

Substance Use/Abuse: Active N/A

In Remission (How long) 0-6 months 6-12 months more than 12 months

Medications/Labs:

Labs: N/A Normal Abnormal (please describe): _____

What is the current status of all symptoms which led to withdrawal?

Please be specific: _____

Is student currently taking medications for above symptoms? Yes No Student declines

If yes, is student compliant with medication? Yes No

Please describe medication (s), date (s) prescribed, and side effects. _____

Continued Treatment Recommendations: _____

Not enough information to make an assessment at this time.

I have examined this individual and have completed this form based upon my own personal assessment of the individual's health status.

I have not examined this individual personally, but have based my assessment on a thorough review of the medical chart and/or consultation with the treating provider.

Provider Name:		Date:	
Provider Signature:		License No.	
Name of Institute:	Telephone No.	Fax No.	
Name of Person Completing Form (if not provider):		Date:	
Signature		License No. (if applicable)	
Name of Institute:	Telephone No.	Fax No.	

If student is receiving treatment from other providers, please indicate:

Provider Name:	Telephone No.
----------------	---------------

Please attach any relevant information that would help us make a decision.