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	
Are you a F-1or J-1 International Student? Yes ☐ No ☐ *Please meet with UC Berkeley International Office to discuss impact of medical withdrawal on F1/J1 immigration status.*	
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 UC 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:____

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☐ Please consider a reduced course load for the following reasons:____________________

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

	No Impairment	Mild Impairment	Moderate Impairment	Significant Impairment	Severe Impairment
Concentrating	☐	☐	☐	☐	☐
Reading	☐	☐	☐	☐	☐
Writing	☐	☐	☐	☐	☐
Ability to attend class	☐	☐	☐	☐	☐
Ability to multi-task	☐	☐	☐	☐	☐
Ability to complete complex tasks	☐	☐	☐	☐	☐
Ability to follow through	☐	☐	☐	☐	☐
Ability to work collaboratively w/peers	☐	☐	☐	☐	☐
Ability to self-motivate	☐	☐	☐	☐	☐
Other__________________	☐	☐	☐	☐	☐

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

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Treatment History (Check all that apply):
☐ Psychiatric ☐ Substance abuse ☐ Medical ☐ Evaluation only

Outpatient treatment within: ☐ 6 months ☐ 1year ☐ 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

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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

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Medications/Labs:

Labs: ☐ N/A ☐ Normal ☐ Abnormal (please describe):____

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

Please be specific:____

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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. ______________________________________

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Continued Treatment Recommendations: ____

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☐ 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.

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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.