HEALTH EVALUATION FORM

For
Medical Withdrawal
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, 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 and sign the outside seal.***

The student named below is requesting a medical leave from the University or California, Berkeley. The information you provide will be used in helping reach a determination. 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:
Term: ☐ Fall ☐ Spring Semester: 20_____	Student ID#:	DOB:
THE FOLLOWING INFORMATION SHOULD COMPLETED BY TREATING PROVIDER ONLY		
Diagnosis:		**Date of Diagnosis:**

Check below any condition that would interfere with student academic performance:

	Mild	Moderate	Significant	Severe	N/A
Concentrating	☐	☐	☐	☐	☐
Reading	☐	☐	☐	☐	☐
Writing	☐	☐	☐	☐	☐
Ability to attend class	☐	☐	☐	☐	☐
Other_____	☐	☐	☐	☐	☐

Risk Assessment (Check those which currently apply):

							Unable to assess
Risk of medical instability	☐ Not at all	☐ Mild	☐ Moderate	☐ Severe	☐ Current or	☐ Past (date):_____	☐
Risk of suicide:	☐ Not at all	☐ Mild	☐ Moderate	☐ Severe	☐ Current or	☐ Past (date):_____	☐
Risk of violence:	☐ Not at all	☐ Mild	☐ Moderate	☐ Severe	☐ Current or	☐ Past (date):_____	☐
Self-injurious behavior:	☐ Not at all	☐ Mild	☐ Moderate	☐ Severe	☐ Current or	☐ Past (date):_____	☐

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 or emergency room visit, please include discharge summary with this form

Comment:

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

# of appts. to date:_____ # of appts. 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:_____

Continue on other side

Treatment Approach: (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:_____

Symptoms which make or made student unable to continue studies. What is the current status of these symptoms?

Please specify:_____

_____

_____

_____

_____

_____

Substance Use/Abuse: ☐Active ☐ In Remission ☐ N/A

Symptoms have been present for as long as: ☐ 0-6 months ☐ 6-12 months ☐ more than 12 months

Medications/Labs:

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

_____

_____

_____

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. _____

_____

_____

_____

Treatment Recommendation: _____

_____

_____

☐ 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.

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

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

Provider Name:	Date:
Provider Signature:	License No.
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.