Boston University Student Health Services
881 Commonwealth Ave - West
Boston, MA 02215
Phone: 617-353-3569 Fax: 617-353-1128
www.bu.edu/shs

Community Provider report for Medical Review

This form must be completed by a licensed healthcare professional (e.g., MD, DO, Psychologist, Social worker, LMHC, NP, CNS)

Student's Name:_____Date of Birth:_____

Provider Name:_____ Specialty:_____

NPI/License#_____

Address: _____

Phone #:_____ Email:_____

Date of treatment: First visit: _____ Last visit: _____

Number of visits with this student: _____

Are you currently treating this student: ___Yes ____ No

Diagnosis or Medical Condition(s) you are treating this student for (ICD-10/DSM-5) :

_____

_____

Current prescribed medications:

_____

_____

Current Functioning:

Has there been significant improvement in the student's medical or mental health condition since they took their medical leave or since you began treatment? _____ Yes _____ No

Has progress been sustained for at least one month? _____ Yes _____ No

What evidence has the student demonstrated to suggest that they can manage their diagnosis when returning to school. Please keep in mind the academic environment can be stressful:

_____
_____
_____

Please indicate if the following symptoms have reduced. If the student has never exhibited a listed symptom, please mark "N/A":

	Yes	No	N/A
Suicidal ideation			
Suicidal behaviors			
Self-injurious behaviors			
Substance Abuse			
Mania			
Psychosis			
Disordered eating behaviors			
Other:			

Please describe any action steps the student has taken to reduce the above symptoms.

_____
_____
_____

Enrollment recommendation: (please note, for undergrads full-time in Fall & Spring is considered 12 or more credits which is typically a minimum of 3 classes; Summer is 8 credits or 2 classes per session)

_____ Student is **ready** to return to school as a **Full-time** student.

_____ Student is **ready** to return to school as a **Part-time** student.

_____Student is **not ready** to return to school at this time.

Additional comments on recommendation:

_____
_____

Treatment recommendations: (Check one)

_____ Ongoing treatment while student is at BU **is not** recommended.

_____ Ongoing treatment while student is at BU **is** recommended:

_____ With current provider

_____ New provider name: _____

Additional treatment plan recommendations:

***Please note**: We are available to advise regarding resources in the community and with the referral process. We also have groups available in Behavioral Medicine to supplement ongoing treatment (sample schedule available here):*

https://www.bu.edu/shs/behavioral-medicine/services-we-provide/behavioral-medicine-groups/

_____ _____

Healthcare Providers Signature ***Date***

Please return completed form to:

Boston University Student Health Services

881 Commonwealth Ave - West

Boston, MA 02215

Fax 617-353-1128 or Email to: shsecure@bu.edu