HEALTH EVALUATION FORM
For
Medical Withdrawal
University of California, Berkeley

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 record, but will be retained in a separate administrative file. Upon completion, please mail the form ***and a copy of your Release of Information*** *to: University Health Services, Social Services, 2222 Bancroft Way, room 2280, Berkeley, CA 94720, phone 510-642-6074. You can fax the form to our confidential fax machine at 510-643-0211.*

Student Name (Last, First, MI):		**Date:**
UHS#:	**Student ID#:**	**DOB:**
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__________________	☐	☐	☐	☐	☐

GAF score (if applicable): Current:__________________Highest past year:____________________

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

Comment:

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:

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:____

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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):________________________________

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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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☐ 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):

☐ 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.
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.