

# HEALTH EVALUATION FORM

For

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

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. Upon completion, please mail the form **and a copy of your release of information** to: University Health Services, Social Services Unit, 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.

<b>Student Name (Last, First, MI):</b>		<b>Date:</b>
<b>UHS#:</b>	<b>Student ID#:</b>	<b>DOB:</b>
<b>Diagnosis:</b>		<b>Date of Diagnosis:</b>

**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 full-time study at 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: \_\_\_\_\_

- 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"/>

GAF score (if applicable): Current: \_\_\_\_\_ At Onset of Treatment: \_\_\_\_\_

**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 within:       6 months       1 year       2-5 years

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

**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 Person Completing Form (if not provider):		Date:
Signature		License No. (if applicable)
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.**