



Treatment Information Form

To the Clinician: The purpose of this assessment is to provide professionals at Tulane with as complete an understanding as possible of the conditions, treatment type and course, and level of functioning of the Tulane student you have been treating. This form is part of the required documentation for returning to Tulane from a Medical Withdrawal. We appreciate your thoroughness in providing the information requested.

Please return this document to medreturn@tulane.edu or fax to (504) 865-6769 Attn: Director, CMVSS.

Clinician Information

Name:

Address:

Credentials/Profession:

License Type and Number:

Student Information

Name:

Date of Birth:

Dates of Service:

Number of Visits:

Treatment Information

Diagnosis or presenting problems:

What initial recommendations did you make?

What types of treatment services were provided by you?

Briefly describe the course of treatment with this student.

Describe how the student did or did not fully engage in the recommended treatment process.

Do you believe the student is prepared to return to full-time student status and independent living at Tulane? Yes No

Please explain:

Supports

Below are support services the student may be referred to. What types of support do you believe would make this student’s chances of success more likely? Please check all that apply.

- | | |
|-------------------------|----------------------------------|
| Alcohol/Drug Assessment | Alcohol/Drug Recovery Community |
| AA/NA/SMART Support | Therapy – Type |
| Group Therapy – Type | Psychiatry/Medication Management |
| Support Group – Type | Medical Specialist – Type |
| Physical Therapy | Occupational Therapy |
| Nutrition Support | Accessibility/Accommodations |
| Case Management Support | Academic Success Coaching |
| Career Coaching | Employment |
| Life Skills Coach | Executive Function/ADHD Coach |
| Other | |

Signature:

Date: