Treating Agent's Reinstatement Questionnaire

Instructions: This form is to be completed only by the treating physician, psychiatrist, licensed psychologist, licensed clinical social worker, or licensed professional counselor. Please respond to the questions listed below and **attach a statement of recommendation for reinstatement on your office letterhead**. Send the completed form and statement to the address indicated. (If more space is needed to complete responses please feel free to place responses on your letterhead and attach to this form.)

1. Full name of client:____

2. Are you a ___psychiatrist, ___licensed psychologist, ___licensed clinical social worker, ___licensed professional counselor, ___other (please specify) ___________________________________?

3. Did you provide the treatment for the above named client? ___Yes ___No

4. Has the above named client completed treatment? ___Yes ___No

5. When did the treatment commence?____________________________ Conclude?_______________________

6. Describe treatment: (include any hospitalization)____
____
____
____
____
____
____
____
____
____
____
____

7. How many treatment sessions have you provided for the client (relating to this matter)?____________________

8. Is the client presently on medication? ___Yes ___No

9. Indicate medication(s) and dosage(s). ____
____
____
____

10. In your estimation, will client need to continue medication? ___Yes ___No

Comments:____
____
____
____

11. If the client has not completed treatment, how frequently will the client need to see you?__________________

12. Have you referred the client for continuing treatment? ___Yes ___No. If yes, please indicate the name, address, and phone number of the individual or agency.
____
____
____
____

(Over)

13. Why have you referred the client for continuing treatment? ____
____
____
____
____

14. If you have referred the client for continuing treatment, do you believe he/she would be able to function appropriately as a student at a University without that continued treatment? ___Yes ___No

15. Do you consider that the client presently, or in the reasonably foreseeable future, may be a threat to his/her own life or the lives of others? ___Yes ___No
Comment: ____
____
____
____
____

16. Do you think this client is capable of carrying a full academic load (12-19 credit hours) at a University?
___Yes ___No

17. To your knowledge, are the parents and/or legal guardian of the client aware of the problem(s) for which you have provided treatment? ___Yes ___No

18. Other Comments: ____
____
____
____

______________________________	______________________________	____________________
(Signature of Treating Agent)	**(Printed name of Treating Agent)**	**(Date)**

****

Note: ***Please remember to attach a statement of recommendation for reinstatement using your <u>office letterhead.</u> The Reinstatement application will not be accepted for consideration unless it includes this completed questionnaire and letter of recommendation submitted on your office letterhead. This information is <u>confidential</u> and will be used as an aid to make a recommendation to the Dean of Students for the purpose of reinstatement.***

Return to:

Director,
Counseling Center,
Suite S-200
3003 N. Charles St.,
Baltimore, MD. 21218-2690.