RE-ENROLLMENT QUESTIONNAIRE AND TREATMENT SUMMARY

INSTRUCTIONS
This form is to be completed by medical professional(s) that have been treating the student for at least six months and are currently treating the student. Please respond to the questions listed below and attach a brief statement of recommendation for student's anticipated re-enrollment and return to campus together with a treatment summary on your office letterhead. Send the completed form and accompanying documentation to the following address:

Manager, Student Conduct
Student Development Centre, ST 400
Brock University
500 Glenridge Avenue
St. Catharines, Ontario
L2S 3A1

(905) 688-5550 ext. 4041

PLEASE RESPOND TO ALL QUESTIONS

Full name of patient: _____

What is your professional clinical qualification? o Psychiatrist o MD o Licensed Psychologist o Other _____

Did you provide treatment for the above named patient? o Yes o No

How many treatment sessions have you provided for the patient (relating to the matter involving Brock University and its community) and over what period of time?

_____

_____

Has the above patient completed treatment? o Yes o No

Are you continuing to provide treatment? o Yes o No

If not, was treatment terminated with your approval? o Yes o No

When did treatment commence?_____

When did the treatment conclude?_____

If the patient has not completed treatment, how frequently will the patient need to see you?

_____
_____

Have you referred the patient for continuing treatment? o Yes o No

If yes, please include the name, address, and phone number of the referral individual or agency: _____
_____

Why have you referred the patient for continuing treatment? _____
_____
_____

If the patient is continuing treatment, do you believe she/he would be able to function appropriately as a student at this university without that continued treatment? o Yes o No

Do you consider that the patient, presently or in the reasonably foreseeable future, is likely to be a danger to him/herself or others, or a threat to her/his life or the lives of others? o Yes o No

If yes, please explain:_____
_____
_____
_____

Do you think that the patient is capable of carrying a full academic load (12-18 classroom hours)? o Yes o No

To your knowledge, are the parent(s) and/or legal guardian(s) of the patient aware of the problem(s) for which you have provided treatment? o Yes o No

Other Comments?

_____
_____
_____
_____

Signature:_____

Name:_____

Date:_____ License Number:_____

Address:_____

Phone Number:_____ Fax Number: _____