



PART B of Return Application Medical Documents

Duke University

Durham, North Carolina

Trinity College of Arts & Sciences/ Pratt School of Engineering

HEALTH Recommendation for Readmission (please make as many copies as you need of this sheet)

TO THE APPLICANT: Fill in your name and forward this form to your recommender. For the convenience of the recommender, you should include a stamped addressed envelope. **This form must accompany the submitted recommendation letter.**

RECOMMENDATION ON BEHALF OF:

Student's Name _____
(please print)

APPLICANT'S WAIVER OF RIGHT OF ACCESS TO CONFIDENTIAL STATEMENT: I hereby voluntarily waive my right of access to any information contained on the recommendation form and agree that the statement will remain confidential.

(student signature)

(date)

Only the recommender should write in this section.

TO THE RECOMMENDER: Please attach a letter confirming the dates during which the applicant has worked under your supervision. We ask that you comment on the applicant's character and work habits as well as the quality of work performed. The review committee will consider your recommendation when evaluating the applicant's request for readmission. Due to federal legislation which allows students access to view their records, Duke University cannot guarantee the confidentiality of your statement unless the applicant has signed the waiver printed above.

Candidate provided this form to me on _____.
please indicate date

THIS RECOMMENDATION LETTER WAS WRITTEN BY:

Print recommender's name

Professional position/title

Please mail directly to the following address:

Regular postal mail:

Dean Sabrina Thomas, Director
Office of Student Returns
Duke University
Box 90052
Durham, NC 27708

overnight/express service ONLY:

Dean Sabrina Thomas, Director
Office of Student Returns
011 Allen Building
Duke University
Durham, NC 27708

Please **DO NOT RETURN** your completed recommendation **TO THE APPLICANT**.
This **COVER LETTER MUST ACCOMPANY YOUR RECOMMENDATION LETTER**.

DUKE UNIVERSITY
OSR Office of Student Returns
TRINITY COLLEGE OF ARTS AND SCIENCES

COVER LETTER TO THE HEALTH PROFESSIONAL:

You are currently treating a Duke student who wishes to return from a Medical Leave of Absence. We are asking you to write a letter to the student's review committee and provide the information requested below, so that we can determine if the student has recovered sufficiently to resume academic responsibilities at Duke. We also ask that you fill out the attached brief questionnaire regarding your treatment of the student and any continued care recommendations.

Please return your letter and questionnaire to:

Regular postal mail:

Dean Sabrina Thomas, Director
Office of Student Returns
Duke University
Box 90052
Durham, NC 27708

Express service ONLY:

Dean Sabrina Thomas, Director
Office of Student Returns
Duke University
011 Allen Building
Durham, NC 27708

or fax it to 919-668-6393. Send your letter between October 1 and November 1 if the student plans to return for the spring semester, between March 1 and April 1 for a return for the summer session, and between June 1 and July 1 for the fall semester.

If you have any questions, please call 919-684-2075 or email officeofstudentreturns@duke.edu.
Thank you for your help.

CHECK LIST

- Describe the problem(s) that led this student to take a Medical Leave of Absence
- Provide your opinion as to whether the student is able to return to Duke at this time and successfully engage a full course load (of four semester credits). If student is not ready to return in a full course load, will an additional term away better prepare the student to engage in a full course load?
- List any medications that you have prescribed for this student, any side effects that may affect the student's ability to attend and complete classes, whether any prescribed medications need to be monitored, and name of treatment provider monitoring this medication.

<http://trinity.duke.edu/osr>

TREATING DOCTOR'S RE-ENTRY QUESTIONNAIRE

Instructions: This form is to be completed by the treating physician, other M.D., or licensed mental health provider. It will be reviewed by the appropriate licensed Duke Health professional. **Your assessment is important. The student's application will not be reviewed without your submitted materials.** Please respond to the questions listed below and attach a brief statement of recommendation for re-entry and a treatment summary **on your office letterhead**. Send the completed form and statement directly to: Dean Sabrina Thomas, Director, Office of Student Returns, Duke University, Box 90052, Durham, NC 27708. *Materials may also be faxed to 919-668-6393. Address questions to email: officeofstudentreturns@duke.edu*

This form must be submitted by the health care provider directly to the Office of Student Returns.

Please Respond to All Questions

Full name of patient: _____

Are you a: ___ Psychiatrist ___ Other M.D. ___ Licensed Mental Health Provider

Did you provide treatment for the above named Patient? ___ Yes ___ No

Please list the particular health conditions/concerns you diagnosed in your assessment of the patient along with treatment start date, end date, completion status and total treatment sessions.

	Start Date	End Date	Total <u>Treatment</u> Sessions	Treatment Completed?	Treatment Ended With Your Permission?
Diagnosis #1 _____	_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> referral
Diagnosis #2 _____	_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> referral
Diagnosis #3 _____	_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> referral

If you referred the patient for continuing treatment for any diagnosis, to whom did you make the referral?

Diagnosis #1 _____	Referred to: _____	<small>provider name</small>	<small>professional title/position</small>	<small>address</small>
Diagnosis #2 _____	Referred to: _____	<small>provider name</small>	<small>professional title/position</small>	<small>address</small>
Diagnosis #3 _____	Referred to: _____	<small>provider name</small>	<small>professional title/position</small>	<small>address</small>

Please indicate any specific intensive treatment program in which student participated while on leave.

If student has not completed treatment for the any diagnosis/condition listed above and a referral was not made, are you continuing to provide treatment? ___ Yes ___ No. **Specify diagnosis** _____

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

What are the continued care needs for this patient?

If the patient is continuing treatment with you or someone else, do you believe he/she would be able to function appropriately as a student at this University without that continued treatment? ___Yes ___No

In your care of this student, do you consider there to be any safety concerns? ___Yes ___No

If yes, under what conditions could this be foreseeable?

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

Has the patient signed the enclosed two-way "release of information" granting Duke's Counseling and Psychological Services (CAPS) permission to disclose health care information to you and you, in turn, to them for the purpose of determining the student's readiness to return to Duke and continuity of care? ___yes ___no

Has the student signed, and placed on file in your home office, a "release of information" to allow you to speak directly with the review committee regarding their readiness to return to Duke and continuity of care, should a conversation be requested? ___yes ___no

Other comments:

Signature of Treating Professional

Date

Name of Treating Professional (please print or type)

Phone Number

Address of Treating Professional

This form must be submitted by the health care provider directly to the Office of Student Returns.

Dean Sabrina Thomas, Director

Office of Student Returns

Duke University

Box 90052

Durham, NC 27708

Materials may also be faxed to 919-660-0488

Address questions to 919-684-2075 or email: officeofstudentreturns@duke.edu

Duke's Counseling and Psychological Services
(CAPS)

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name _____ Date of Birth ___/___/___ DUID # _____

I _____ hereby authorize Counseling and Psychological Services (CAPS)
(Client or Personal Representative)

of Duke University to disclose specific health information from the records of the above named client to:

1) Duke's Office of Student Returns and my review committee.

2) _____
(Provider/Agency) (Address/Phone/Fax)

3) _____
(Provider/Agency) (Address/Phone/Fax)

4) _____
(Provider/Agency) (Address/Phone/Fax)

for the specific purpose(s) of: Determining my readiness to return to Duke and establishing an appropriate treatment plan or health care expectations should I be approved to return.

Specific information to be disclosed by CAPS: Clinical history at Duke Counseling and Psychological Services (if any), to include prior treatment history gathered, diagnoses (if applicable), and treatment recommendation issued.

Furthermore, I request and authorize the above named provider/agency to release the following information back to CAPS in order to assess my readiness to return to Duke and facilitate continuity of care:

I understand that this authorization will expire on the following date, event or condition: _____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year. I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. To revoke this authorization, I must do so in writing by signing the *Revocation Section* on the back of this form. Requests to revoke this authorization should be directed to Jeff Kulley, Associate Director for Clinical Services, at (919) 660-1000.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, or psychological or psychiatric conditions this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my eligibility for services at CAPS.

I further understand that I may request a copy of this signed authorization.

(Signature of Client)

(Date)

(Witness)

(Signature of Personal Representative)

(Date)

(Personal Representative Relationship/Authority)

Please submit this signed form directly to:
or fax 919-660-0488

Dean Sabrina Thomas, Director
Office of Student Returns
Duke University
Box 90052
Durham, NC 27708

**REVOCATION SECTION
of Duke's Counseling and Psychological Services (CAPS)**

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
Please Keep This Portion for Your Records**

Please keep a copy of this sheet for your personal files. Complete it only when you are revoking your authorization to disclose health information. If you should misplace this sheet, you may request another one from the Duke's Counseling and Psychological Services (CAPS) at 919-660-1000 or the Office of Student Returns email officeofstuentreturns@duke.edu, 919-684-2075.

I do hereby request that this authorization to disclose health information of _____
(Name of Client)
signed by _____ on _____
(Name of Person Who Signed Authorization) *(Date of Signature)*
be rescinded, effective _____. I understand that any action taken on this authorization prior to the
(Date)
rescinded date is legal and binding.

<i>(Signature of Client)</i>	<i>(Date)</i>	<i>(Signature of Witness)</i>	<i>(Date)</i>
<i>(Signature of Personal Representative)</i>	<i>(Date)</i>	<i>(Personal Representative Relationship/Authority)</i>	

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authorization by _____
(Name of Client or Personal Representative)
on _____. The client or his personal representative has been informed that any action taken on
(Date)
this authorization prior to the rescinded date is legal and binding.

<i>(Signature of Staff)</i>	<i>(Date)</i>	<i>(Signature of Witness)</i>	<i>(Date)</i>
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Requests to revoke authorization should be directed to Jeff Kulley, Associate Director for Clinical Services, at (919) 660-1000.