DUKE UNIVERSITY

REQUEST TO WITHDRAW FROM A COURSE FOR MEDICAL REASONS: ATTENDING HEALTH CARE PROVIDER'S QUESTIONNAIRE

This form is to be completed by the physician, other M.D., or licensed mental health provider treating the student. It will be reviewed by the student's academic dean and, among other factors,[1] will inform his/her decision **whether to authorize a student to withdraw from a course to an underload for medical reasons**. Please respond to the questions listed below and have the student sign a waiver of confidentiality so that the dean can contact you with any questions that may arise about the student's treatment history.

Please Respond to All Questions

Full name of patient: _____

Are you a: ____Psychiatrist ____ Other M.D. ____ Other Health Care Professional

Have you provided treatment for the above-named patient? ____Yes ____No

What is the diagnosis/condition being treated? _____

How many treatment sessions have you provided? _____ Has the patient complied with the treatment? ____Yes ____No

Comments (optional): _____

Has the patient completed treatment? ____Yes ____No Are you continuing to provide treatment? ____Yes ____No

If you are no longer treating the patient, was treatment terminated with your approval? ____Yes ____No

When did the treatment commence? _____ Conclude? _____

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

What specific treatment regimen do you propose this student follow in the future? _____

_____

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 student's parents/legal guardian(s) aware of the problem(s) for which you have provided treatment? ____Yes ____No

In what ways do you think this student's medical issues affect or may affect his or her ability to perform academically. Please be specific. *(feel free to extend your comments on the back of this form)*

_____

Has the student signed a waiver, permitting the student's academic dean to speak with you? ____Yes ____No

Signature of Treating Professional: _____ *Date:* _____

Name of Treating Professional (please print) _____ *Phone Number:* _____

Address of Treating Professional: _____

PLEASE RETURN THE COMPLETED FORM TO THE STUDENT'S ACADEMIC DEAN AT DUKE UNIVERSITY

[1]Including such things as the student's medical history, use of available resources, compliance with medical recommendations, and how the student has managed his/her academic responsibilities to date, etc.