UNIVERSITY OF DENVER

Center for Academic and Career Development
2050 E Evans Ave, Suite 30
Denver, CO 80208
303.871.2455
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Treating Health Care Provider Questionnaire

Instructions: This form is to be completed by the treating physician, other M.D., licensed mental health provider, or other qualified health care provider. Please respond to the questions listed below and attach a brief statement concerning whether this student is prepared to resume full-time study and a treatment summary on your office letterhead. Send the completed form and statement to

Lisa Matye Edwards
University of Denver
2050 E. Evans Ave, Ste 30
Denver, CO 80208
303.871.3331 (fax)
303.871.2455 (phone)
lmedward@du.edu

Please respond to all questions.

Full name of student/patient: ______________________________________

Are you a: ☐ Psychiatrist ☐ Other M.D. ☐ Licensed Mental Health Provider
_______________________________________Other (Specify)

Did your provide treatment for the above named patient? ☐ Yes ☐ No

How many treatment sessions have you provided (relating to this matter)?____________

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

Has this patient completed treatment? ☐ Yes ☐ No

Are you continuing to provide treatment? ☐ Yes ☐ No

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

When did the treatment commence? _________ 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? ☐ Yes ☐ No

If yes, please indicate the name, address, and the phone number of the individual or agency. ____

What are the continued care needs for this patient?____________________________

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If the patient is continuing treatment with you or someone else, do you believe the patient would be able to function as a full-time student at the University of Denver **without** continued treatment? ☐ Yes ☐ No

Do you consider there to be any safety concerns? ☐ Yes ☐ No
If yes, please describe your concerns. ______________________________________

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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

Other comments:____

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________________________________ ___________________________
Signature of Treating Professional Date

________________________________ ___________________________
Name of Treating Professional (type or print) Phone Number

____
Address of Treating Professional

Please remember to attach a brief statement of recommendation for re-entry on your office letterhead and a treatment summary. The student's re-entry application will not be accepted for review unless it includes these materials.