WAKE FOREST
UNIVERSITY

Campus Life
Student Health Service
University Counseling Center

Directions for Students Taking Medical/Mental Health Leave

The enclosed cover letter, questionnaire, and FERPA authorization are to be used for WFU Wake Forest University students who are taking a medical withdrawal for either general medical conditions or for mental health conditions. As a part of this type of leave from the university, students are expected to address the medical and/or mental health condition(s) which necessitated the absence. This includes engaging an appropriate licensed medical/mental health professional as a part of the care for these issues. Students will need to complete the attached FERPA Authorization for your provider prior to giving them this form. It is then recommended that the enclosed documentation is provided to the licensed provider at the beginning of a student's treatment so that they understand what information needed from them. Undergraduate students should contact the Office of Academic Advising with any questions related to a leave from the university, while students from Wake Forest University graduate and professional schools should contact their relevant school administrator.

WAKE FOREST UNIVERSITY

AUTHORIZATION FOR DISCLOSURE OF INFORMATION IN EDUCATION RECORDS

The Family Educational Rights and Privacy Act of 1974 (FERPA) provides certain rights and protections to students regarding the disclosure of their education records maintained by the University. These education records include files, documents and materials in whatever medium which contain information directly related to a student and from which a student can be individually identified.

By signing this Authorization, you hereby authorize Wake Forest University, acting through its employees and/or agents, to disclose the following information from your education record:

_____

_____

_____

The above information from your education records will be disclosed to the following individual(s) or class of individuals for the purpose(s) specified:

Please specify the name(s) of individual(s) or the class of individuals who are authorized to receive information from the education record and the purpose for the disclosure:

_____

_____

_____

This Authorization may be revoked at any time by submitting a written revocation to _____. Such revocation will not affect disclosures made prior to receipt of the written revocation. Unless earlier revoked, this Authorization will remain in effect for the 20__-20__ academic year.

I hereby voluntarily authorization Wake Forest University to disclose the above specified information from my education records to the individual(s) designated herein. I understand that I may request a copy of the records disclosed.

_____ _____

Signature of Student Date

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Dear Licensed Medical/Mental Health Professional,

Your client/patient has taken a medical leave of absence from Wake Forest University. When this student is interested in returning to Wake Forest University to pursue his/her education, the student must provide verification from a licensed professional that:

- she/he has followed through with a course of treatment appropriate to the condition(s) which necessitated her/his departure from the university,
- there is limited likelihood that the condition will return to the degree that it will necessitate a subsequent medical withdrawal, and
- she/he is ready to resume full-time student status.

To help facilitate this process, please complete and return the following to the Wake Forest University Counseling Center:

- *Readmission Questionnaire for Medical/Mental Health Withdrawal* (enclosed)
- A brief treatment summary on office letterhead with your professional opinion about whether the student is ready to resume full-time study at Wake Forest University

Additionally, to facilitate this process please obtain a release of information, signed by the student, which will permit you to communicate with any clinical provider of the Wake Forest University Student Health Service (for general medical conditions) and of the University Counseling Center (for mental health conditions) regarding the student's course of treatment and any recommendations for continued care. Our communication with you in this matter will be essential in the reenrollment consideration process for the student.

Warmly,

Cecil D. Price, MD
Director
Student Health Service

Daniel M. Paredes, Ph.D. NCC, LCMHCS
Acting Director
University Counseling Center

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Readmission Questionnaire for Medical/Mental Health Withdrawal

Instructions: This form is to be completed by a licensed medical and/or mental health provider. For general medical conditions which necessitated a withdrawal from the university, this form should be completed by the licensed medical provider from whom you received care. If the medical withdrawal was for a mental health condition(s) (e.g., mood disorder, alcohol other drug disorder, eating disorder, etc.) this form should be completed by the licensed mental health professional from whom treatment was received.
Please respond to all of the questions listed below and attach a separate treatment summary – including a statement of recommendation – on your office letterhead.

Full name of student: _____

Please check the discipline(s) in which you have an active license:
Psychiatry ☐ Psychology ☐ Professional Counseling ☐

Clinical Social Work ☐ Marriage and Family Therapy ☐

Physician/Nurse Practitioner/Physician's Assistant ☐

Other ☐ _____

Did you provide treatment for the above named student? Yes ☐ No ☐

To date, how many treatment sessions/office visits have you provided for the student related to the reason for their medical/psychological withdrawal? _____

Please indicate any specific treatment (medications, surgery, physical therapy etc) or treatment program (e.g., Outpatient therapy/treatment, Partial hospitalization, Inpatient hospitalization, etc.) the student participated in while on leave.

_____

_____

_____

Has the above student successfully completed treatment? Yes ☐ No ☐

On what date did the treatment commence? _____

On what date did the treatment conclude? _____

If the student has not completed treatment, describe the ongoing treatment plan under your care:
_____

_____

Has the treatment plan for the patient's condition included the use of prescription medications?

Yes ☐ No ☐

If yes, please indicate medication(s), dosage, and schedule: _____

_____

Is it recommended that the student remain on these medications if she/he were to return to Wake Forest University?
Yes ☐ No ☐

If yes, will you continue to prescribe and monitor the patient's medication(s) or will the patient need a referral to a local medical provider? _____

_____

Have you referred the student for continued treatment to another provider or agency appropriate for their concerns?
Yes ☐ No ☐

If yes, please indicate the name, address, and phone number of the provider and/or agency:

_____

_____

What are the continued care/treatment needs for this student?

_____

_____

Will the student require any temporary or ongoing accommodations related to their medical/mental health condition (i.e., housing, meal plan, academic accommodations)?

If yes please specify: _____

_____

_____

While in your care were there any increased risk-related concerns (e.g., suicide, homicide, self-injury, psychosis, alcohol/other drug use, etc.)? Yes (If Yes, please elaborate below) ☐ No ☐

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

In your professional opinion, is the student ready to return as a full-time student and take on the academic, social, residential, and other demands of student life? Yes ☐ No ☐

Please explain the reason(s) for your answer in the statement to be submitted with this questionnaire.

Other comments to assist with the student's successful transition to Wake Forest University:

_____

_____

_____

_____ _____

Signature of Provider Date

_____ _____

Name of Provider (please print/type) Phone Number

_____

Address of Provider

Please remember to attach a brief statement of your professional opinion regarding readiness for reenrollment on your office letterhead as well as a treatment summary.

For medical withdrawal related to general medical concerns please return to:
Student Health Service
Wake Forest University

Box 7386
Winston-Salem, NC 27109
Phone: 336-758-5218
Fax: 336-758-6054

For medical withdrawal related to mental health condition please return to:
University Counseling Center
Wake Forest University
Box 7838
Winston-Salem, NC 27109
Phone: 336-758-5273
Fax: 336-758-1991

Completion of this documentation does not guarantee the student readmission to the university, but is a requirement for consideration.