Date:	/	1	



Provider Assessment a	nd Release Form	COUNSELING CENTER
To the provider of care for:		
The student named above is required to provide a current to their receipt of medical and/or psychological services safely return to class and/or resume living on campus.		
All students wishing to return to campus following emergements provide adequate documentation of ability to return plan. This information will be used to make a decision accommodations based on a disability must be made by the Center for Student Success, which is located in So complete your assessment and to make recommendation Please return as soon as possible, as this student's ability this information.	n to campus and a comple about returning to the un the student to Student Acolution Central. Please use stor follow-up care and tre	eted continuity of care niversity. Requests for ccessibility Services in the attached form to eatment of this student.
Please return this completed form via mail or fax to:	Tiffany Guthrie, MS, LPC Counseling Center Direc	
Mailing address:	Fax number:	
Robert Morris University Counseling Center 6001 University Boulevard	412-397-5920	
Patrick Henry Center, Lower Level		
Moon Township, PA 15108		
Note: Feel free to attach additional documentation on a s	separate sheet if necessary	γ.
Name of Student:		
Provider name and credentials:		
Address:	_	
Telephone number:	Fax number:	
Email address: (optional)		

Date of last contact with student:

Diagnoses or diagnostic impressions:

Current medicat	ions, doses:
Name of Student:	
Summary of eva	luations:
Nature of injury/ - Physical injury/ (please descri - Suicidal or hon - Self-injurious b - A/V hallucinatio - Special consid	Ilness or illness be) nicidal ideation ehavior
-	ssessment, is this student emotionally and/or physically stable and adequately urn to class and/or resume living on campus? Yes No
If no, please exp	lain:
treatment. Please who require psych	elow your recommendations for and arrangements with the student for follow up note, the RMU Counseling Center no longer provides psychiatric treatment. Students liatric care must make arrangements with a provider in the area. dations for continued treatment or therapy:
•	dent been referred to another provider in the University area? Yes No please provide the following:
Provider name and credentials:	
Address:	
Phone number:	
Fax number:	
3) Other rec	ommendations, concerns or comments:
Signature:	Date:
	e Number:
Thank you for you	ur time and attention to this matter.