

Physician's Assessment and Recommendation
Regarding Patient's Readiness for UVa Reenrollment

(please write very legibly)

Date: _____

Patient's Name: _____ DOB: _____

Physician Providing This Report:

Name and Degree: _____

Business Address: _____

Phone: _____

Fax#: _____

Treatment Information:

Date of patient's initial appointment with you: _____

Date of patient's last appointment with you: _____

Specific prescribed medications and dosages: _____

Summary of treatment: _____

Your recommendation regarding patient's readiness to return to academic enrollment:

_____ Pt is ready to resume full-time academic reenrollment

_____ Pt is not ready to resume full-time enrollment, but it is recommended that he/she enroll part-time

_____ Pt is not yet ready to resume any academic enrollment.

Comments: _____

Recommended treatment plan if pt returns to UVa enrollment:

_____ Continued treatment is not necessary at this time

_____ Pt will remain in treatment with current provider(s)

_____ Treatment should be transitioned to UVa or Charlottesville provider(s)

Additional comments: _____

Signature of Provider

Date

Please fax completed form to: (434) 243-9669, Attention: Nursing Supervisor