

SYRACUSE UNIVERSITY
COUNSELING CENTER



Dear Licensed Mental Health Professional,

Your client has taken a medical leave of absence for psychological reasons from Syracuse University. When this student is ready to return to Syracuse University, the student must provide verification from a licensed mental health care professional that they have followed through with an appropriate course of treatment, that their condition has improved for a sufficient period of time, and that they are ready to resume full-time student status.

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

1. Licensed Mental Health Care Professional Readmission Questionnaire (enclosed)
2. A brief treatment summary on office letterhead that recommends resuming full-time study at Syracuse University

Mail to:
Syracuse University Counseling Center
Attn: MLOA
200 Walnut Place
Syracuse, NY 13244

Fax to: 315.443.4276

Additionally, to facilitate this process, please obtain a release of information signed by the student permitting you to speak with a therapist from the Syracuse University Counseling Center regarding the student's course of treatment and continued care recommendations. Our communication with you in this matter will be essential in the readmission process for the student.

We appreciate your help. If you have any questions, please feel free to call the SU Counseling Center at 315.443.4715.

Sincerely,

Cory Wallack, Ph.D.
Director, Syracuse University Counseling Center



Licensed Mental Health Professional Readmission Questionnaire

Instructions: This form is to be completed by a Licensed Mental Health Professional. Please respond to the questions listed below and attach a brief statement of recommendation for readmission and a treatment summary on your office letterhead.

Please Respond to All Questions

Full name of student: _____ Student's DOB: _____

Profession/ Credentials: _____

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

How many treatment sessions have you provided for the student (relating to this matter)? _____

Please indicate any specific treatment program student participated in while on leave. (E.g. Outpatient therapy, Partial hospitalization, inpatient etc) _____

Has the above student completed treatment? Yes No

Are you continuing to provide treatment? Yes No If not, was treatment successfully completed? Yes No

When did the treatment commence? _____ Conclude? _____

If the client has not completed treatment, how frequently will she/he need to see you? _____

In your care of this student were medications prescribed? Yes No

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

Will the student remain on these medications when he/she returns to Syracuse University? Yes No

If yes, what is the plan for medication management? _____

Have you referred the student for continuing treatment? Yes No

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

What are the continued care needs for this student?

While in your care were there any safety concerns (suicide risk, homicide risk, etc)? Yes No

If yes, please explain: _____

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

Other comments to assist the student's successful transition to Syracuse University: _____

Name of Treating Professional (please print or type): _____

Phone # of Treating Professional: _____

Address of Treating Professional: _____

X _____ **Date:** _____

Signature of Treating Professional

**Please remember to attach a brief statement of recommendation for readmission on your office letterhead and a treatment summary.*

Return to:

Counseling Center

Attn: MLOA

200 Walnut Place

Syracuse, NY 13244-2480.

The student will not be able to be readmitted to Syracuse University without these materials.