Return from Medical Leave of Absence

HEALTHCARE PROVIDER REPORT

This completed form must be received **directly from the Healthcare Provider.** Please have your clinician(s) email or fax the Healthcare Provider Report and signed Authorization for Release to:

Email: MLOA-Returns@med.mit.edu

Fax: (877) 932-6537
Attn: Medical Leave Coordinator

The attached Healthcare Provider Report is to be completed by a healthcare provider (or providers) who has treated you during your medical leave from MIT. Usually this includes but is not limited to outpatient physicians/physician assistants/nurse practitioners, therapists, and counselors. If you received care from more than one clinician, please ask the clinician with whom you have worked most recently to complete this form. If you received treatment at a residential facility or day program (e.g. partial hospital program, intensive outpatient program) or inpatient hospital **AND** you did **NOT** receive outpatient care, please have a clinician from the treating facility complete this form. This form should be sent directly from the clinician(s) to MIT Medical (address above) and **NOT** to Student Support Services or the Committee on Academic Performance (CAP) at MIT. As such, the information provided in this form is considered confidential health information and will be entered into your medical record at MIT Medical.

1) Fill out and sign an Authorization for Release of Protected Health Information for each clinician that will be completing the Healthcare Provider Report.
2) Fill out the initial section of the Healthcare Provider Report (To Be Completed by Student) then give both the form and signed Authorization for Release to your clinician(s) to complete.

Checklist:

- ☐ Signed Authorization(s) for Release of Protected Health Information.
- ☐ Completed Healthcare Provider Report(s)

Return from Medical Leave of Absence

HEALTHCARE PROVIDER REPORT

TO BE COMPLETED BY STUDENT:

Student Name: _____ DOB: _____

MIT Student ID number: _____

Mailing address: _____

Phone number: _____ Email address: _____

Semester for requested return: _____

Treatment Modalities received since taking leave of absence (please check all that apply):

- ☐ Individual therapy
- ☐ Group therapy
- ☐ Medication management
- ☐ Physical/Occupational Therapy
- ☐ Inpatient hospitalization
- ☐ Day treatment (e.g. IOP, PHP)
- ☐ Residential treatment
- ☐ Outpatient medical care
- ☐ Eating disorder treatment
- ☐ Nutrition counseling
- ☐ Substance use treatment program
- ☐ Other: (please specify)

TO BE COMPLETED BY THE HEALTHCARE PROVIDER:

Section A

Full Name: _____ Degree/Licensed as: _____

Mailing address: _____

_____

Phone number: _____ Fax number: _____

Date of first contact: _____ Date of most recent contact: _____ Total number of sessions: _____

Was patient seen in-person for appointments? ◯ Yes ◯ No, explain:

Diagnoses/areas of need for which student received treatment:

Was the leave of absence related to a behavioral health issue(s)? If yes, then complete sections B and C. If no, skip to section C.

Section B

Please describe the treatment in which you and the student have been engaged (e.g. CBT, DBT, psychodynamic, etc.):

Please comment on your observation of the student's progress over the course of treatment and the student's degree of compliance:

Has the student completed treatment? If not, what treatment do you recommend the student continue while in school (e.g. skills based therapy, specialized care for eating or substance use disorder, etc.)?

Has there been a substantial improvement of the student's *original condition* sufficient for you to believe the student is ready to effectively and safely function as a student at MIT? ◯ Yes ◯ No ◯ N/A

This substantial improvement has been maintained on a stable basis for: ____ days/weeks/months
(circle one)

If no, please explain.

Has there been a substantial reduction of any of the following safety-related behaviors in which the student may have been engaging?

Suicidal ideation	◯ Yes	◯ No	◯ N/A
Suicidal behaviors	◯ Yes	◯ No	◯ N/A
Self-injury behaviors	◯ Yes	◯ No	◯ N/A
Substance Use behaviors	◯ Yes	◯ No	◯ N/A
Failure to maintain ideal body weight for height	◯ Yes	◯ No	◯ N/A
Food bingeing or restricting	◯ Yes	◯ No	◯ N/A
Food purging or any other potentially harmful compensatory behaviors used for weight management (e.g. use of laxatives, excessive exercise, etc.)	◯ Yes	◯ No	◯ N/A
Behaviors that threaten others (e.g. violence, stalking, etc.)	◯ Yes	◯ No	◯ N/A
Others (please specify):	◯ Yes	◯ No	◯ N/A

The substantial reduction (of above behaviors) has been maintained for _____ days/weeks/months
(*circle one*)

If behavior is nutrition related, please write a brief statement about the student's nutrition status:

What changes have you noticed that demonstrate the student has increased ability to manage stress and cope with life demands:

What specific plans regarding the prevention of relapse or recurrence of similar problems have you and the student discussed:

During the student's leave from MIT, has the student demonstrated the ability to function autonomously in a job, volunteer position, college course, or other position which is supervised and evaluated or graded?

◯ Yes ◯ No ◯ N/A

If yes, please describe:

Please remark on the student's ability to participate in the intensive, high pressure, living and learning environments at MIT:

Section C

Is the student presently on medication? ◯Yes ◯No

If yes, please specify medications and dosages:

In your professional judgement, is the student healthy enough to effectively and safely participate in campus life at MIT, with or without reasonable accommodations? ◯Yes ◯No

If yes, please provide any additional information, comments, or special considerations which you believe would be helpful in deciding on the student's application to return to MIT.

If no, please explain.

Provider signature: _____ Date: _____