External Provider Recommendation for Mental Health Medical Leave

To be completed by a Licensed Mental Health or Licensed Medical Provider and sent to :
Nicole Muller, LCSW-R Director of The Counseling Center at Siena College
Phone: 518-783-2342 Fax: 518-786-5069

Form intended to be completed prior to the start of a student's leave. *In extenuating circumstances the leave request can still be considered if this is completed, signed and received within 48 hours of the student's requested leave start date.*

Name of Student: ____ Student's DOB: ______________

Name of Licensed Provider Completing Form: ____
License Type and Number: ____
Licensed Provider's Contact information: ____
Phone number: ____
Fax: _________________________________ Email:_______________________________________

Student's DSM V Diagnosis:

It is in my professional opinion that the above mentioned student who I have assessed &/or treated, should be approved for medical leave due to the following reasons (Please check all that apply) **:**

___ Student is experiencing suicidal ideation &/or behavior that places them at risk of harm to self

___ Student is experiencing self injury that places them at risk of harm to self

___ Student is experiencing mental health symptoms that place them at risk of harming others

___ Student is experiencing active psychosis that is interfering with their activities of daily living &/or places them or others at risk of harm

___ Student is experiencing debilitating mental health symptoms that are preventing them from being able to leave their residence and/or attend classes and related academic activities

___ Student is experiencing active and debilitating symptoms and function impairment due to an acute trauma

___ Student is experiencing disordered eating that places their health and safety at risk

If there are other circumstances not captured above, please contact The Director of Counseling Center.

Anticipated timeframe for medical leave: _____ calendar days (estimate)

____ ____________________

Licensed Provider Signature Date