Wellesley College Health Service
106 Central Street
Wellesley, MA 02481
Phone: 781-283-2810 Fax: 781-283-3693

Community Clinician Report Form

NOTE: This form is to be completed by the student's primary care clinician and/or subspecialist and mailed to the following address: **Wellesley College Health Service, 106 Central Street Wellesley, MA 02481, Attn: Director**

Clinician Name _____ Student Name _____

Specialty and Degree _____ Date of Birth _____

License # _____ Year of Graduation_____

State of Licensure _____ Duration of Care for Medical Leave Diagnosis(es)_____

Date of Most Recent Visit _____ Number of Clinical Visits in past 12 months _____

Diagnosis(es) pertinent to medical leave _____

Current Medications and dosages_____

Please provide your professional judgment in response to the following questions regarding the student named above.

___Yes ___No Has there been improvement in the student's condition related to her medical leave?

Please explain:
_____
_____

If applicable, has there been a reduction in any of the following safety related behaviors that the student may have been engaging in?
___Yes ___No Self injurious behavior (safety-related)
___Yes ___No Substance abuse behaviors
___Yes ___No Failure to maintain weight at minimum of 85% of Ideal Body Weight for height
___Yes ___No Food Binging
___Yes ___No Food purging or any other potentially harmful compensatory behaviors used for weight management (e.g. use of laxatives, excessive exercise, etc.)

___Yes ___No Once achieved, has the improvement been maintained for three or more consecutive months?

Please describe:
_____
_____

___Yes ___ No Has the student complied with medication management/treatment plan as recommended?

Please explain:
_____
_____

Wellesley College students engage in a highly demanding course of study and are required to be able to live and work independently (with or without accommodation) and are expected to be a productive member of the community.

___Yes ___No Do you have any concerns about this student's ability to be successful in such a setting?

Please explain:
_____
_____

Please identify the accommodations, medications with dosages and/or ongoing treatment recommended to maximize the student's likelihood of success:_____

_____

_____ _____
Clinician Signature Date

_____
Clinician Printed Name

Address:_____

Phone:_____ Fax:_____

Please use the space below or attach an additional page to expand upon your responses to the above questions. Please include the most recent set of vital signs and BMI as well as the date on which they were recorded. Any additional comments or observations you may wish to make are welcomed.