

**Center for Counseling and Student Wellness  
Hobart & William Smith Colleges  
91 St. Clair Street, Geneva, NY 14456  
Phone 315-781-3388 Fax 315-781-4455**

**Community Provider Report Form**

**NOTE: This form is to be completed by the student's community mental health clinician/service provider and mailed by the provider directly to the Counseling Center Staff at the address indicated above.**

Provider's Name \_\_\_\_\_ Student Name \_\_\_\_\_

Licensed as \_\_\_\_\_ Date of First Session \_\_\_\_\_

License # \_\_\_\_\_ Date of Most Recent Session \_\_\_\_\_

State of Licensure \_\_\_\_\_ Total # of Treatment Sessions \_\_\_\_\_

Initial DSM Axis I Diagnosis Initial DSM Axis V Diagnosis  
\_\_\_\_\_

Current DSM Axis I Diagnosis Current DSM Axis V Diagnosis  
\_\_\_\_\_

Other Diagnoses or Clinical Issues \_\_\_\_\_

**Please provide your professional judgment in response to the following questions:**

\_\_\_ Yes \_\_\_ No Has there been a substantial amelioration of the student's original medical/psychological condition?

If yes, please check all of the following that you have observed a marked reduction of in this student:

- \_\_\_\_\_ Number of symptoms
- \_\_\_\_\_ Severity of symptoms
- \_\_\_\_\_ Persistence of symptoms
- \_\_\_\_\_ Functional impairment
- \_\_\_\_\_ Subjective level of client distress

\_\_\_ Yes \_\_\_ No If achieved, has the substantially improved condition been maintained stably for three consecutive months?

Has there been a substantial reduction of any of the following safety related behaviors (mark N/A if not applicable)?

- \_\_\_ Yes \_\_\_ No \_\_\_ N/A Suicidal behaviors
- \_\_\_ Yes \_\_\_ No \_\_\_ N/A Self injury behaviors
- \_\_\_ Yes \_\_\_ No \_\_\_ N/A Substance abuse behaviors
- \_\_\_ Yes \_\_\_ No \_\_\_ N/A Failure to maintain weight at minimum of 90% of Ideal Body Weight for height
- \_\_\_ Yes \_\_\_ No \_\_\_ N/A Food binging
- \_\_\_ 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 Other: \_\_\_\_\_

\_\_\_ Yes \_\_\_ No If achieved, has the substantial reduction in safety related behaviors been maintained stably for three consecutive months?

Additional Comments:

Clinician Signature \_\_\_\_\_ Date \_\_\_\_\_