UNIVERSITY OF NOTRE DAME
University Health Services
Premiere. Student. Health Care.

Release of Information for Readmissions Process

I,_____, authorize the following agencies/persons:
(Name)

Agency/Persons A

University Health Services

Saint Liam Hall

Notre Dame, IN 46556

P 574/631-7103 F 574/631-5012

Agency/Persons B

Time Away Coordinator
(Name)

Center for Student Support & Care
(Title)

228 Coleman Morse

Notre Dame, IN 46556

P 574/631-7833 F 574/634-0108

To make the following transaction:
_____Agency/Person A disclose information specified below to Agency/Person B.
_____Agency/person B disclose information specified below to Agency/person A.
_____Agency/Person A and B disclose information specified below to each other.

I authorize the release of the following information: **readmission materials, including any relevant medical information requested by University Health Services.**

For the purpose of: **processing readmission request to make a recommendation to the Time Away Coordinator.**

This authorization shall remain in effect until: *the end of the academic year for which readmission is sought.* I understand that I may revoke this consent at any time by giving written notice to the person or organization making disclosure.

_____ _____
Print Name of Client/Former Client Street Address, City, State, Zip

_____ _____ _____
Signature of Client/Former Client Phone Date

NOTICE: This information has been disclosed from records, which are confidential. Any further disclosure without the specific written consent of the person to whom it pertains exceeds the limits of this release.

UNIVERSITY OF NOTRE DAME
University Health Services
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Release of Information for Treating Agent

PERMISSION FOR RELEASE OF INFORMATION

I, _____, authorize the following agencies/persons:
(Name)

Agency/Persons A	**Agency/Persons B**
University Health Services Staff Name, Title	_____ Name, Title
University Health Services Organization	_____ Organization
Room 201 Saint Liam Hall Street Address	_____ Street Address
Notre Dame, IN 46556 City, State, Zip	_____ City, State, Zip
(574) 631-7103 (574) 631-5012 Phone Number Fax Number	_____ Phone Number Fax Number

To make the following transaction:
_____ Agency/Person A disclose information specified below to Agency/Person B.
_____ Agency/person B disclose information specified below to Agency/person A.
__X___Agency/Person A and B disclose information specified below to each other.

I authorize the release of the following information: **medical records including hospitalization if any**, **treatment information, and any medication records, Treatment Provider Questionnaire and letter of recommendation on physician's letterhead.**

For the purpose of: **processing readmission request to make a recommendation to the University of Notre Dame.**

This authorization shall remain in effect until*: the end of the academic year for which readmission is sought.*

I understand that I may revoke this consent at any time by giving written notice to the person or organization making disclosure.

_____ Print Name	_____ Street Address
_____ Signature	_____ City, State, Zip
_____ Date	_____ Phone

NOTICE: This information has been disclosed from records, which are confidential. Any further disclosure without the specific written consent of the person to whom it pertains exceeds the limits of this release.

UNIVERSITY OF NOTRE DAME
University Health Services
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Returning Student Questionnaire

Please review the following questions. Attach your responses to this form and return both to: Attention: Diana Custer (dcuster@nd.edu) University Health Services, Saint Liam Hall, Room 201, University of Notre Dame, Notre Dame, IN 46556.

Print Your Name: _____ E-Mail Address: _____

Current Address: _____ Phone Number: _____

Signature: _____

Date of departure from the University of Notre Dame: _____

Applying to return _____Fall _____Spring _____Summer _____Year

Today's Date: _____

1. Please describe the circumstances involved in your decision to depart from the University of Notre Dame.

2. How have you addressed and resolved those issues that precipitated your departure?

3. Please describe why you feel you are ready to return to the University of Notre Dame.

4. Please describe what steps you will take to assist you in your transition back to the university and the pressures of academic work, on/off campus living, social life, athletic and/or organizational commitments, etc.

5. Do you feel that you need additional care/treatment when you return to the university to assist you in your transition? If yes, what care/treatment would you require to assist you with this transition (e.g. medication management, medical follow up, etc.)? If you feel you do not need care/treatment at this time, why not?

Thank you for taking the time to provide your thoughtful perspective as we review your returning materials.

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Treatment Provider Readmission Questionnaire

Instructions: This form is to be completed only by the treating physician, psychiatrist, licensed psychologist or licensed professional counselor. Please respond to the questions listed below and **attach a brief statement of recommendation for readmission on your office letterhead**. Send the completed form and statement to the address indicated.

1) Full name of patient: _____

2) Are you a medical doctor? If so, what are your credentials? _____

3) Did you provide care or treatment for the above-named patient? ____ Yes ____ No

4) Has the patient been discharged/released from your care? ____ Yes ____ No

5) When did the treatment commence? _____Conclude_____

6) Describe treatment: (include any hospitalization) _____
_____
_____

7) Is the patient currently on medication? ____ Yes ____ No
Describe: _____
_____

8) In your estimation, will patient need to continue medication? ____ Yes ____ No
Comments: _____
_____
_____

9) If the patient has not been discharged from your care, how long is the treatment expected to continue? _____

10) Have you referred the patient to continue care or treatment? ____ Yes ____ No.
If yes, please indicate the name, address, and phone number of the individual or agency.
_____

11) Why have you referred the patient to continue care or treatment?
_____
_____
_____

Saint Liam Hall
Notre Dame, Indiana 46556-0709
(574) 631-7497 ▪ (574) 631-6047 fax
uhs.nd.edu
Exceptional college health care, infused with our Notre Dame values, to foster lifelong well-being