WILLIAM & MARY
DEAN OF STUDENTS OFFICE
Office Phone: 757-221-2509
Fax: 757-221-2538

Health Care Provider Assessment Form—
Honor Council
(Psychological)

Student Name: _____

Person providing this assessment: _____

MD (Psychiatrist) Psychologist Social Worker Licensed Counselor (Circle all that apply)

Other: _____

State of Licensure: _____ Phone Number: _____

License Number: _____ Fax: _____

Section A

Date of initial appointment: _____ Date of most recent appointment: _____

Total number of times you have seen the student: _____

Treatment modalities provided: _____

☐ Psychotherapy ☐ Pharmacotherapy

Other:_____

Formal Diagnoses:

_____

_____

Diagnostic Impressions:

_____

_____

_____

_____

_____

Level of Severity of Conditions (choose one): Mild Moderate Severe Unknown

Prognosis: _____

Continue on Following Page

Current Medications and Dosages:

_____ _____

_____ _____

_____ _____

_____ _____

Section B

Please record the symptoms that the student has demonstrated.

	Circle the appropriate response for each
Attention & Concentration Difficulties	Yes No N/A
Body Image/Eating Issues	Yes No N/A
Depressive Symptoms	Yes No N/A
Homicidal Ideation/Intent	Yes No N/A
Interpersonal Difficulties	Yes No N/A
Mood Instability	Yes No N/A
Motivational Difficulties	Yes No N/A
Obsessions/Compulsions	Yes No N/A
Panic Symptoms	Yes No N/A
Post Traumatic Symptoms	Yes No N/A
Psychosis	Yes No N/A
Self-Harming (non-suicidal)	Yes No N/A
Sleep Disturbance	Yes No N/A
Social Phobia	Yes No N/A
Substance Abuse/Dependence	Yes No N/A
Suicidal Ideation/Intent	Yes No N/A
Other (please explain)	Yes No N/A

Continue on Following Page

Have the student's conditions had an impact on their ability to:

- Exercise their moral reasoning/judgment (circle one) YES NO NOT SURE
  If yes, please elaborate including dates when student's abilities were compromised.

- Regulate their behavior (circle one) YES NO NOT SURE
  If yes, please elaborate including dates when student's abilities were compromised.

Section C

By signing where indicated below I am representing to William & Mary that my response to each question listed above is true, complete, and accurate to the best of my knowledge and belief, that it constitutes my best professional judgment and opinion, and that the Patient did not prepare or draft that response for my signature.

Signature:_____ Date: _____

Please fax or email this information to Community Values & Restorative Practices (F: 757-221-2538; cvrp@wm.edu). If you have any questions, please contact us at 757-221-2509.