SUMMARY OF PSYCHOLOGICAL CARE

By Non-UC Berkeley Providers

Dear Mental Health Care Provider,

A UC Berkeley student who has been under your care is requesting an adjustment to their class schedule. Your assessment of the student's condition and progress would be much appreciated by the College. After you have completed this form, please attach your business card and seal the form in an envelope. Please sign across the seal and give the envelope to the student to submit with their request. Thank you for your assistance.

For Completion by Student

Student Name _____ Student ID Number _____

Email Address _____ Phone Number _____

Academic term for which schedule adjustment is being requested: ☐ Fall ☐ Spring ☐ Summer Year _____

Note: A separate "Summary of Psychological Care" form is needed for each semester that an adjustment is requested.

For Completion by Provider

Provider Name _____ Position or Title _____

Provider Signature _____ Date _____

Date of patient's first visit _____ Total number of visits _____ Number of visits during the period in question (see box checked above by student) _____

Please check the academic functions and symptoms that were affected *during the period in question* (see box checked above by student) because of the student's condition, and indicate the severity of the impairment *during that period.*

Definitions of severity ratings on back.

Academic Function	**1-Mild**	**2-Moderate**	**3-Significant**	**4-Severe**	**5-N/A**
Concentrating	❑	❑	❑	❑	❑
Reading	❑	❑	❑	❑	❑
Writing	❑	❑	❑	❑	❑
Ability to attend class	❑	❑	❑	❑	❑
Other_____	❑	❑	❑	❑	❑

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Student Name _____ Student ID Number _____

Definitions of severity ratings below

Symptom	**1-Mild**	**2-Moderate**	**3-Significant**	**4-Severe**	**5-N/A**
Low energy	❑	❑	❑	❑	❑
Anxiety	❑	❑	❑	❑	❑
Sleep problems	❑	❑	❑	❑	❑
Other_____	❑	❑	❑	❑	❑

Treatment Progress

Rate the degree of impact the presenting problem has on the student's level of functioning by checking the appropriate number.

	1-Mild	**2-Moderate**	**3-Significant**	**4-Severe**
At the time of first session:	❑	❑	❑	❑
During period identified by the student on page 1:	❑	❑	❑	❑
Now:	❑	❑	❑	❑

Please provide any other information that may be helpful to us in making our decision (e.g. problems with medications; any significant relapses, including timing of relapses; hospitalizations; anything else that would significantly affect academic performance):

ESTIMATED DEGREE OF IMPACT ON ACADEMIC PERFORMANCE

1	Mild Impact	Medical condition may intermittently affect patient's ability to concentrate
2	Moderate Impact	Medical condition may impact patient's ability to attend classes and/or concentrate.
3	Significant Impact	Medical condition requires significant investment in treatment. Class attendance impaired.
4	Severe Impact	Medical condition may require hospitalization and on-going investment in treatment.