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 his/her 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 his/her request. Thank you for your assistance.

For Completion by Student:

Student: _____ UCB SID #: _____

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 (print): _____ Provider Signature: _____

Position or Title: _____ 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 are at the end of the second page

Academic Function	**1–Mild**	**2–Moderate**	**3-Significant**	**4-Severe**	**5-Profound**
Concentrating	☐	☐	☐	☐	☐
Reading	☐	☐	☐	☐	☐
Writing	☐	☐	☐	☐	☐
Ability to attend class	☐	☐	☐	☐	☐

Other_____

Definitions of severity ratings are at the end of this page

Symptom	**1–Mild**	**2–Moderate**	**3-Significant**	**4-Severe**	**5-Profound**
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 circling the appropriate number (1 being the least severe and 5 being the most severe).

At the time of first session:

LEAST 1 2 3 4 5 MOST

During period identified by the student on page 1 of this form:

LEAST 1 2 3 4 5 MOST

Now:

LEAST 1 2 3 4 5 MOST

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**	Condition may intermittently affect patient's ability to concentrate.
2	**Moderate Impact**	Condition may impact patient's ability to attend classes and/or concentrate.
3	**Significant Impact**	Condition requires significant investment in treatment.
4	**Severe Impact**	Condition requires a significant investment in treatment. May require hospitalization.
5	**Profound Impact**	Condition has profoundly impacted all aspects of patient's academic and personal life.