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

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?
_____
_____
_____

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