LEAVE OF ABSENCE RETURN ASSESSMENT FORM

As per *Policy on Student Involuntary Leave of Absence* (PRVPA-15)

Last Updated - August 2020

- **This form is to be completed by a licensed practitioner from the Province of Québec, Canada. The University may, at its own discretion, accept a form completed by a practitioner licensed in another jurisdiction. The student is responsible for any required official/certified translation. The University reserves the right to require that the student provide any additional opinion(s) and/or documentation.**

- **Note that the practitioner may not use this form or any other means to refer a student/patient to any physician or resource at Concordia Wellness and Support Services (this includes Health Services and Counselling and Psychological services) for any follow-up or continued treatment.**

- **The consent to waive patient confidentiality is provided by the patient at the bottom of the present form.**

1. Name of patient:

2. Date of birth (YYYY/MM/DD):

3. Degree, professional qualifications and license number of the practitioner:

Degree	Name of Professional Order	License No.
MD		
PhD		
MA		
Other		

4. How long has the patient been in treatment with you?

   What is the frequency of the visits?

5. Has the above patient completed treatment? ☐ Yes ☐ No

   If no, please indicate the reasons why, and the estimated date of treatment termination:

6. Are you continuing to provide treatment? ☐ Yes ☐ No

   If no, was treatment terminated with your approval? ☐ Yes ☐ No

7. Have you referred the patient for continuing treatment elsewhere? (Note the point above stating that no referrals can be made to Concordia Wellness and Support Services)

   ☐ Yes ☐ No

   If yes, please include the name, address, and phone number of the referral individual or agency.

8. Why have you referred the patient for continuing treatment?

9. If the patient is continuing treatment with you or another professional, is it your opinion that such continued treatment is necessary to ensure that the patient is able to resume and perform their academic and University related activities?

☐ Yes ☐ No

10. Do you consider that this patient, presently or in the reasonably foreseeable future, is likely to be a danger or threat to themselves or others?

☐ Yes ☐ No

If yes, please explain:

11. Has the patient been advised to restrict/reduce their academic activities?

☐ Yes ☐ No

If yes, please indicate which activities:

12. Has the patient been advised to restrict/reduce their course load?

☐ Yes ☐ No

If yes, how many courses should be taken (maximum) per term?

When do you think that the patient would be capable of carrying a full academic load (12 – 18 classroom hours per week or in the case of graduate students, 40 academic work hours per week)?

What type of courses should not be taken (i.e. courses with group work, performance courses, on-line courses, internships, stages, etc…)?

13. Does the patient have any other exclusions or limitations that are likely to affect the student's reintegration into the University? ☐ Yes ☐ No

If yes, please note any exclusions or limitations here:

14. Other comments?

Name:

License Number:

Address:

Phone number: Fax number:

Date (YYYY/MM/DD):

Signature:

Authorization of the Patient

I, the undersigned, hereby release the above mentioned signatory of the present document from any and all applicable patient-practitioner or other confidentiality restrictions or obligations. Furthermore, I allow and permit my practitioner(s) named above to discuss my health, including mental health and fitness to pursue my studies with the designated University official and to provide same with any relevant documentation.

Signed at Montreal on (YYYY/MM/DD):

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(Student signature)