COLLEGE OF APPLIED HEALTH SCIENCES

Disability Resources & Educational Services
1207 S. Oak St., MC-574
Champaign, IL 61820

Dear Medical/Mental Health Provider:

This form is provided as a courtesy to students of the University of Illinois who are requesting psychological evaluation through Disability Resources and Educational Services (DRES) at the University of Illinois. The student listed below is requesting you complete this form.

The purpose of the form is to assist DRES and the student with determining the best possible campus and/or community resources for their current stressors. Examples of these resources include: directly registering with DRES and immediately receiving supports, a psychological evaluation to diagnose current symptoms in order to register with DRES, or referral to other support agencies (e.g. Counseling Center, McKinley Health Center, community resources).

DRES engages in an interactive process with the student to determine the best referral or support for the student. Completion of this form does not guarantee DRES will provide a psychological evaluation for the student.

Questions regarding this form can be directed to DRES.

Student information	
Legal Name:	UIN:
Other/Preferred Name (if applicable):	Net ID:
Address (including City, State, and zip code):	
Current Phone:	Current Date:
Anticipated Graduation (Fall/Spring/Summer and year):	
Gender (optional): ☐ Female ☐ Male ☐ Transgender ☐ Non-binary ☐ Other:	
Pronouns (optional): ☐ She/Her ☐ He/Him ☐ They/Them ☐ Other:	

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Provider Information (to be completed by provider only)	
Name:	License #:
Specialty:	State(s) of license:
Address (including City, State, and zip code):	
Current Phone:	Current Date:
Treatment dates: / / to / /	
Length of treatment with student/approximate number of visits with student:	

telephone 217-333-1970 • *VRS* 217-689-0564 • *fax* 217-244-0014
url http://www.disability.illinois.edu

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Brief Physical Health Screening

☐ I have evaluated the student, and the following conditions may be having an impact on their current symptoms (check all that apply):		
☐ Sleep disturbances	☐ In the past	☐ Currently
☐ History of Seizures	☐ In the past	☐ Currently
☐ Traumatic Brain Injury (please describe):	☐ More than one year ago	☐ within the past year
☐ Chronic Health Problem (please specify)	☐ In the past	☐ Currently
☐ Other medical/Health problem (please describe):	☐ In the past	☐ Currently
☐ Other medical/Health problem (please describe):	☐ In the past	☐ Currently

☐ I have evaluated the student and the student **has no medical history** which could be causing their current symptoms.

☐ I have **not evaluated** the student's medical history.

☐ I have **referred the student** to another provider/specialist to evaluate medical causes of their current symptoms.	
Name of referral provider:	Date of referral:

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Brief Mental Health Screening

☐ I have evaluated the student, and the following conditions/treatments may be having an impact on their current symptoms (check all that apply):		
☐ Depression (moderate to severe)	☐ In the past	☐ Currently
☐ Anxiety (moderate to severe)	☐ In the past	☐ Currently
☐ Substance Use Disorder	☐ In the past	☐ Currently
☐ Special Education Services (please describe)	☐ In the past	☐ Currently
☐ Diagnosis of a specific learning disability (please specify):	☐ In the past	☐ Currently
☐ Treatment from a talk therapist	☐ In the past	☐ Currently
☐ Medication treatment for mental health problems (e.g. prescription medication for mental health disorders)	☐ In the past	☐ Currently
☐ Other mental health problem (please describe):	☐ In the past	☐ Currently
☐ Other mental health problem (please describe):	☐ In the past	☐ Currently

☐ I have evaluated the student and the student **has no medical history** which could be causing their current symptoms.

☐ I have **not evaluated** the student’s mental health history.

☐ I have **referred the student** to another provider/specialist to evaluate their symptoms.	
Name of referral provider:	Date of referral:

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Brief Life Events Screening

☐ I have discussed recent life events with the student, and the following stressor may be having an impact on their current symptoms:		
☐ Traumatic event directly to them	☐ More than one year ago	☐ Within the last year
Brief description (e.g. car accident, death, sexual assault, severe illness) (Optional):		
☐ Traumatic event to someone close to the student	☐ More than one year ago	☐ Within the last year
Brief description (e.g. car accident, death, sexual assault severe illness) (Optional):		
☐ Homelessness	☐ More than one year ago	☐ Within the last year
Brief description (optional):		
☐ Other significant stressor	☐ More than one year ago	☐ Within the last year
Brief description (optional):		
☐ Other significant stressor	☐ More than one year ago	☐ Within the last year
Brief description (optional):		

☐ I have evaluated the student and the student **has no significant life events** which could be causing their current symptoms.

☐ I have **not evaluated** or ruled out any significant life events related to the student's symptoms.

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Provider Narrative (Optional). Any information you'd like to include about the student, their history of symptoms, or your work together can be written here. You may also submit additional documents separately.

Signature of provider

Date

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