PART B of Return Application
Medical Documents

复学申请材料B部分

医疗诊断文件

Duke Kunshan University
昆山杜克大学

HEALTH Recommendation for Return from Leave of Absence/Reinstatement

学生返校/复学健康推荐表

(Please make as many copies as you need of this sheet.) （请根据需要复印此表格。）

TO THE APPLICANT: Fill in your name and forward a copy of this form to each of your health care providers. This form must be completed and submitted by your health care provider(s).
致申请人：请填写你的姓名，并将此表格复印发送给你的每位医疗服务提供者。此表格必须由医疗服务提供者填写并提交。

RECOMMENDATION ON BEHALF OF:
为以下学生推荐:

Student's Name /学生姓名 ____

APPLICANT'S WAIVER OF RIGHT OF ACCESS TO CONFIDENTIAL STATEMENT: I hereby voluntarily waive my right of access to any information contained on the recommendation form and agree that the statement will remain confidential. Falsification of any information or materials submitted with your application is a violation of the code of conduct at Duke Kunshan University. Any concerns regarding misleading or false information will be forwarded to the Dean of Academic Services and/or Dean of Student Experience for additional inquiry. If appropriate, the matter will result in administrative adjustment of my return approval.

申请人放弃查阅保密材料的权力：我自愿放弃查阅推荐表上任何信息的权利，并同意该材料应保持机密。我了解：提交申请时如提供任何虚假信息或材料，都将视作违反昆山杜克大学的行为准则。对于任何涉嫌误导或虚假的信息，将会转发给学术服务院长和/或学生事务院长进行进一步调查; 如经查实，学校将对我的返校批准结果视情况进行调整。

______________________________ ______________________________
(student signature/学生签名) *(date/日期)*

Please notify your health care provider(s) that staff from the university campus clinic and/or CAWS may contact them to verify certain conditions, and advise them to be prepared to respond to such inquiries. If the health care provider(s) have any questions or concerns regarding the questionnaire, please encourage them to reach out directly to the campus clinic for physical health (campushealth@dukekunshan.edu.cn) or CAWS for mental health (caws@dukekunshan.edu.cn).
请告知你的医疗服务提供者，学校诊所和/或心理咨询室的工作人员可能会与他们联系，以核实某些情况，请他们做好答复的准备。如果医疗服务提供者对问卷有任何疑问，请告知他们直接联系校园诊所（身体健康原因）进行相关咨询（campushealth@dukekunshan.edu.cn), 或联系心理健康中心（心理健康原因）进行相关咨询（caws@dukekunshan.edu.cn ）。

Duke Kunshan University

COVER LETTER TO THE HEALTH PROFESSIONAL:

You are currently treating a Duke Kunshan University student who wishes to return from a Medical Leave of Absence. We are asking you to write a letter to the student's review committee and provide the information requested below, so that we can determine if the student has recovered sufficiently to resume academic responsibilities at DKU, in accordance with the attached Description of Certain Essential Requirements and Expectations. We also ask that you fill out the attached brief questionnaire regarding your treatment of the student and any continued care recommendations. Please DO NOT RETURN your completed recommendation TO THE APPLICANT.

昆山杜克大学

致治疗医生：
您目前正在治疗一位希望从昆山杜克大学休学状态复学的学生。我们请您写一封信给学生的复学审核委员会，并提供下面所要求的信息，以便我们确定学生是否已经康复到足以在昆山杜克大学履行学术责任。我们希望您填写以下关于您对学生的治疗以及任何继续护理建议的简要问卷。请不要将您完成的材料交给申请人。

Please return your letter and questionnaire to:
请将您的推荐信和以下问卷提交到如下电子邮箱

For physical health treatment/身体治疗	For mental health treatment/心理治疗
Please send the document via email directly to **请将文件发到以下电子邮箱：** **Email:** campushealth@dukekunshan.edu.cn **电子邮箱：**campushealth@dukekunshan.edu.cn	Please send the document via email directly to **请将文件发到以下电子邮箱：** **Email:** caws@dukekunshan.edu.cn **电子邮箱：**caws@dukekunshan.edu.cn

The deadline for receipt of this letter is 5:00 p.m. China time May 1 for Fall Term and October 15 for Spring Term.

医疗诊断材料的接收截止时间为：学生申请秋季学期学返校的材料提交时间为为中国时间**5月1日下午5点前**，申请春季学期返校的申请材料截止日期为中国时间10月1日下午5点前。

TREATING DOCTOR'S RE-ENTRY QUESTIONNAIRE
学生返校问卷（治疗医生填写）

Instructions: This form is to be completed by the treating physician, other M.D., or licensed mental health provider. It will be reviewed by the appropriate licensed DKU Health professional. **Your assessment is important. The student's application will not be reviewed without your submitted materials.** Please respond to the questions listed below and attach a brief statement of recommendation for re-entry and a treatment summary on your office letterhead. See cover page for address of recipient of this document. Please refer to the attached document, Student Readiness to Return to Duke Kunshan: Descriptions of Certain Essential Requirements and Expectations.

此问卷需要由学生的治疗医生，精神科医生，心理治疗师，或心理咨询师填写。填写后将由昆山杜克大学专业人士审核。

您的评估对学生返校至关重要。如果没有您填写的问卷，昆山杜克大学无法对学生的材料进行审核。
请如实填写以下信息，并附上有您所在单位抬头的说明信，说明您对于学生返校的建议。并将所有材料寄往第二页的地址。

请附上有医院/机构抬头以及医生盖章或签字的患者病历。

This form must be submitted by the health care provider directly to Duke Kunshan University

Please Respond to All Questions

此表格必须由治疗医生直接提交给昆山杜克大学

请填写所有问题

Full name of patient 患者姓名: ______________

Are you a 您是:____Psychiatrist 精神科医生___Other M.D.其他科室医生

____Licensed Mental Health Provider心理治疗师或心理咨询师

Did you provide treatment for the above named Patient您是否给以上患者提供治疗/咨询?___Yes是 ___No否

Please list the particular health conditions/concerns you diagnosed in your assessment of the patient along with treatment start date, end date, completion status and total treatment sessions.
请列出您对于该患者的诊断，以及治疗/咨询开始时间，结束时间，治疗/咨询是否已结束，以及治疗/咨询总次数。

TREATMENT

治疗/咨询

	Start Date 开始日期	End Date 结束日期	Total Treatment Sessions 治疗次数	Treatment Completed? 治疗是否完成	Treatment Ended With Your Permission? 结束治疗是否经过您的同意
Diagnosis #1__________________ 诊断1	________	________	________	❑ Yes是 ❑ No否	❑ Yes是 ❑ No否 ❑ Referral转诊
Diagnosis #2__________________ 诊断2	________	________	________	❑ Yes是 ❑ No否	❑ Yes是 ❑ No否 ❑ Referral转诊
Diagnosis #3__________________ 诊断3	________	________	________	❑ Yes是 ❑ No否	❑ Yes是 ❑ No否 ❑ Referral转诊

If you referred the patient for continuing treatment for any diagnosis, to whom did you make the referral?
如果您转诊患者到其他人或机构处治疗，请提供转诊信息：

Diagnosis诊断 #1______________

Referred to 转诊到: ____
provider name医生姓名 *professional职业* *title/position职位* *address地址*

Diagnosis诊断 #2______________

Referred to 转诊到: ____
provider name医生姓名 *professional职业* *title/position职位* *address地址*

Diagnosis诊断 #3______________

Referred to 转诊到: ____
provider name医生姓名 *professional职业* *title/position职位* *address地址*

Please indicate any specific intensive treatment program in which student participated while on leave.
如果学生在病休期间参与过住院或高强度治疗项目，请说明。

If the patient has not completed treatment for the any diagnosis/condition listed above and a referral was not made, are you continuing to provide treatment?______Yes____No.

如果患者还未完成治疗，也没有被转诊，您是否会继续提供治疗？___是__否

If the patient has not completed treatment, how frequently will the patient need to see you?

如果患者还未完成治疗，患者将需要见您的频率是？

What are the continued care needs for this patient?
患者接下来的治疗需要是什么？

____

____

If the patient is continuing treatment with you or someone else, do you believe he/she would be able to function appropriately as a student at this University **with** continued treatment?

如果患者继续在您或其他人处治疗，您是否认为患者在**继续**治疗的前提下，可以作为大学生正常地学习和生活？____Yes是____No否

In your assessment, do you believe he/she would be able to function appropriately as a student at this University **without** that continued treatment?

经过您的评估，您是否认为患者在**不继续**治疗的前提下，可以作为大学生正常地学习和生活？

___Yes是___No否

In your care of this student, do you consider there to be any safety concerns?

____

____

以您的评估，患者是否有任何伤害自己或他人的风险？___Yes是__No否

If yes, under what conditions could this be foreseeable?

如果患者有伤害自己或他人的风险，在什么情况下会发生？

____

To your knowledge, are the parents and/or legal guardian(s) of the patient aware of the problem(s) for which you have provided treatment?______Yes____No

根据您所了解的信息，患者的家长/法定监护人是否了解患者的诊断与您的治疗？___是___否

Has the patient signed the enclosed "Authorization to Disclose Health Information" granting DKU's Student Health Services (SHS) and/or Counseling and Psychological Services (CAPS) permission to disclose health care information to you and you, in turn, to them for the purpose of determining the student's readiness to return to DKU and continuity of care?______Yes_____No

患者是否已经签署本申请包含的"健康信息告知授权书"，授权昆山杜克大学学生健康服务中心及心理健康中心与您相互告知患者的相关健康信息， 以达到决定学生是否适合复学并继续接受治疗的目的？______是___否

Has the student signed, and placed on file in your home office, a "release of information" to allow you to speak directly with the review committee and/or DKU medical or counseling staff regarding the student's readiness to return to DKU and continuity of care, should a conversation be requested?_______Yes_____No

患者是否签署"信息告知授权书"，允许您直接和昆山杜克大学复学委员会以及或昆山杜克大学医疗或心理中心员工沟通学生是否适合复学并继续接受治疗？ ____是___否

Other comments (Feel free to attach additional information):

补充说明（可附上补充证明材料）

____

____

__________________________________ __________________________

Signature of Treating Professional *Date*

治疗医生签字 *日期*

__________________________________ __________________________

Name of Treating Professional (please print or type) *Phone Number*

治疗医生姓名 *联系电话*

____

Hospital Name and Address of Treating Professional

治疗医院/机构名称以及地址电话

In accordance to Chinese law, if treating doctor/professional works for a hospital, that hospital must be above county level. Is your hospital considered county level?__Yes_No

如果是精神科治疗，患者所治疗的医院是否为三甲医院精神科或精神专科医院？ __是___否

DKU's Student Health Services and Counseling and Psychological Services (CAPS) AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name____Date of Birth__ /__ /__ SIS ID________________

I______________________________________hereby authorize Student Health Services (SHS) and/or Counseling and Psychological Services (CAPS) of Duke Kunshan University to disclose specific health information from the records of the above named client to:

1) DKU Reinstatement Committee.

2) ____

(Provider/Agency) *(Address/Phone/Fax)*

3) ____

(Provider/Agency) *(Address/Phone/Fax)*

4) ____

(Provider/Agency) *(Address/Phone/Fax)*

for the specific purpose(s) of: Determining my readiness to return to DKU and establishing an appropriate treatment plan or health care expectations should I be approved to return.

____

Specific information to be disclosed by Student Health Services and/or Counseling and Psychological Services

____

Furthermore, I request and authorize the above named provider/agency to release the following information back to Student Health Services and/or Counseling and Psychological Services in order to assess my readiness to return to DKU and facilitate continuity of care: ____

I understand that this authorization will expire on the following date, event or condition:

____

I understand that if I fail to specify an expiration date, event or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year. I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. To revoke this authorization, I must do so in writing by signing the *Revocation Section* on the back of this form. Requests to revoke this authorization should be directed to the Student Health Services and/or Counseling and Psychological Services.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my eligibility for services at Student Health Services and/or Counseling and Psychological Services.

I further understand that I may request a copy of this signed authorization.

____________________________ ____________

(Signature of Student/Client) *(Date)*

____________________________ ____________

(Parent/Guardian if under 18) *(Date)*

REVOCATION SECTION

DKU's Student Health Services and Counseling and Psychological Services

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Please Keep This Portion for Your Records

Please keep a copy of this sheet for your personal files. Complete it only when you are revoking your authorization to disclose health information. If you should misplace this sheet, you may request another one from the DKU's Student Health Services or Counseling and Psychological Services at (+86) 0512-36657211.

I do hereby request that this authorization to disclose health information of________________________________

(Name of Client)

signed by____on____________________

(Name of Person Who Signed Authorization) *(Date of Signature)*

be rescinded, effective_______________. I understand that any action taken on this authorization prior

(Date)

to the rescinded date is legal and binding.

_______________________________ ____________

(Signature of Student/Client) *(Date)*

_______________________________ ____________

(Parent/Guardian if under 18) *(Date)*

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authorization by__________________________

(Name of Client or Personal Representative)

on __________________. The client or her/his personal representative has been informed that any

(Date)

action taken on this authorization prior to the rescinded date is legal and binding.

_______________________________ ____________ ___________________________ ____________

(Signature of Staff) *(Date)* *(Signature of Witness)* *(Date)*

Requests to revoke authorization should be directed to DKU's Student Health Services or Counseling and Wellness Services at (+86) 0512-36657211.