PLU WANG CENTER FOR GLOBAL AND COMMUNITY ENGAGED EDUCATION
PACIFIC LUTHERAN UNIVERSITY

PART C - Specialty Provider Consultation (only if required)

(Print) Student Last Name: _____ First_____ Middle_____

Chosen or Preferred Name: _____

Name/location of study away program(s):
(Please list all locations/dates if participating in consecutive programs)

_____

_____

Travel dates: _____

I am requesting that you complete this Medical Specialty Provider Consultation form in order to review my potential needs for study away. I will share this information with Pacific Lutheran University and I give you permission to discuss my situation with the Wang Center for Global and Community Engaged Education and other staff members of the university working to review my potential needs for study away.

Medical/Mental Health Release of Information
I understand that medical information is confidential and protected by federal and state privacy regulations, and I also understand that I may consent to the release of any and all of my health care information. I request and authorize my provider to release any and all medical or mental health care information to PLU as PLU may request. If I have been diagnosed or treated for HIV (AIDS virus), psychiatric disorders/mental health, or drug and/or alcohol use, my provider is specifically authorized to release all health care information relating to such diagnosis or treatment. This release is in effect from the date this document is signed through the date that travel relating to the program is completed.

→ Student Signature: _____ Date: _____

PART II: To be completed by provider.

Request Part A - Student Self-Assessment for review. Please complete and sign this form and return via fax or mail, as soon as possible, to

Wang Center for Global and Community Engaged Education | Pacific Lutheran University
12180 Park Avenue S.
Tacoma, WA 98447
Tel: 253-535-7577 | Fax: 253-535-8752

Thank you for taking the time to meet with this student and complete this form. The student has received a travel health consultation for their intended study away program and they are being referred for an additional consultation prior to travel. Living and studying in an unfamiliar environment can trigger physical and emotional stress and exacerbate current health issues. Familiar or reliable healthcare or medications might not be readily available to the student in their host country.

Student Name (print)_____

You are asked to:

- Discuss the student's healthcare needs with them in light of how it may affect their study away experience.
- If applicable, discuss prescription availability and medication plan with student.
- If applicable, collaborate with the student to complete a written Self-Care Plan and identify with whom the student may need to share their plan. Please indicate "N/A" as necessary.

Check one: ☐ PLU Counseling Center ☐ Non-PLU mental health provider
☐ Non-PLU medical provider

Based on the information provided by the student, including their Student Self-Assessment (Part A), personal review of the student's health history, and review of available medical records, please confirm in your professional opinion (check one):

☐ I have met with the student to discuss their physical/mental health condition(s) or disability(ies) as it relates to their intended study away experience and no further action is recommended.

☐ I have met with the student to discuss their physical/mental health condition(s) or disability(ies) as it relates to their intended study away experience and I recommend the student shares their written Self-Care Plan with the following parties in advance of departure:

_____

_____

☐ I have met with the student to discuss their physical/mental health condition(s) or disability(ies) as it relates to their intended study away experience and I recommend the student consult with the Wang Center in advance of departure to determine if reasonable accommodations are available.

_____

_____

☐ There are medical or mental health contraindications to this student's participation in the program at this time (please describe the contraindications and how they impact the student's participation in this program; submit additional sheets if necessary). I recommend the student consult with the Wang Center to determine if there are accommodations or an alternate program that will accommodate the student's needs.

_____

_____

Licensed Provider's Signature: _____ Date: _____

(Print) Licensed Provider's Name: _____

Office Stamp (with address and phone):