



Stephanie Cummings, Administrative Manager
Recovery Services Division
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RECOVERY SERVICES

STUDENT APPLICATION PACKET

Instructions: Please complete all 8 parts of your Student Application Packet, and fax it to Stephanie Cummings at (617) 353-7700. After receiving your packet, she will contact before the start of the upcoming semester to arrange a brief interview. If you have any questions about the application process or services offered at the Center for Psychiatric Rehabilitation, please refer to the “Living Well” section of our webpage at cpr.bu.edu or contact Stephanie Cummings at (617) 353-3549 or stephc13@bu.edu.

Date Sent:

PART 1: CONTACT INFORMATION

Name: _____
[Last Name] [First] [Middle Initial]

Address: _____
[Street] [Apartment/Suite Number]

[City/Town] [State] [Zip Code]

Phone: _____
[Home] [Cell]

Date of Birth: _____

*Email: _____

*Recovery Center uses email and text messaging to communicate with students. These are not secure modes of communication. By checking this box, you are agreeing to receiving emails and text messages from the center. You are accepting and understanding the risk of having your association with the center, possibly compromised with the use of unsecure email and text messages.

Initials _____ Date: _____

PART 2: CURRENT MEDICAL & PSYCHIATRIC CONDITIONS

Current Medical Conditions

- | | |
|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Heart Attack/Failure |
| <input type="checkbox"/> Cognitive | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Hepatitis _____ (A,B or C) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Angina | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Clinical Obesity | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Dizziness or Fainting Spells | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Ear Problems/Hearing Loss | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Other: _____ |

Current Psychiatric Conditions

- | | |
|--|--|
| <input type="checkbox"/> Alcohol/Substance Abuse | <input type="checkbox"/> Panic Disorder |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Personality Disorder (Borderline, Antisocial, etc.) |
| <input type="checkbox"/> Asperger's Disorder | <input type="checkbox"/> Post-Traumatic Stress Disorder (PTSD) |
| <input type="checkbox"/> Attention Deficit/Hyperactivity Disorder (ADHD/ADD) | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Seasonal Affective Disorder (SAD) |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Sexual & Paraphilic Disorder |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Sleep & Wake Disorder (Insomnia, Narcolepsy, etc.) |
| <input type="checkbox"/> Dissociative Disorder | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hoarding Disorder | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hypochondriasis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Obsessive-Compulsive Disorder (OCD) | <input type="checkbox"/> Other: _____ |

PART 3: DEMOGRAPHIC SURVEY

1. To which gender identity do you most identify?

- Female
 Male
 Transgender Male
 Prefer to self-describe _____
- Gender Variant/Non-Conforming
 Transgender Female
 Prefer not to say

2. What is your date of birth? _____ (MM/DD/YYYY) Age as of April 2017? _____

3. Ethnicity origin (or Race): Please Specify your ethnicity

- White
 Hispanic or Latino
 Black or African American
 Native American or American Indian
- Asian/Pacific Islander
 Other (please specify): _____
 Prefer not to answer

4. What is the highest degree or level of school you have completed? *If currently enrolled, highest degree currently enrolled, highest degree received.*

- No schooling
 Less than High School
 High School Diploma/GED
 Some College
 2-Year College Degree (Associates)
- 4-Year College Degree (BA, BS)
 Master's Degree
 Doctorate Degree
 Professional Degree (MD, JD)

5. What is your current marital status?

- Single/Never Married
 Married
 Separated
- Divorced
 Widowed
 Prefer not to answer

6. What is your current employment status?

- Employed Full-time (40+ hours per week)
 Employed Part-time (1-39 hours per week)
 Not Employed, Looking for Work
 Not Employed, Not Looking for Work
- Retired
 Disabled, Not Able to Work
 Prefer not to answer

7. What is your current religious affiliation?

- Christian
 Jewish
 Buddhist
 Muslim
- Hindu
 Unaffiliated
 Other (please specify): _____
 Prefer not to answer

8. Military Status:

- No, Military Service
 Armed Forces – Reserves
 Dependent Family Member
 Prefer not to answer
- Armed Forces – Active Duty
 Armed Forces/National Guard
 National Guard – not mobilized
 other (please specify): _____

9. Citizenship Status

- Us Citizen by Birth (Native)
 Permanent Resident
 Non-resident Allen- Visa type _____ Exp. Date: _____
- Us Citizen Naturalized

PART 4: EMERGENCY CONTACT INFORMATION

In case of a *medical emergency*, please contact the following person:

Name:

Relationship:

Address:

Phone (Primary):

Phone (Secondary):

In case of a *personal emergency*, please contact the following person:

Name:

Relationship:

Address:

Phone (Primary):

Phone (Secondary):

PART 5: PROFESSIONAL SUPPORTS

Primary Care Physician

Name:

Medical Facility/Clinic/Program:

Address:

Phone (Primary):

Phone (Secondary):

PART 6: PROFESSIONAL SUPPORTS CONTINUED

Psychiatrist

Name:

Medical Facility/Clinic/Program:

Address:

Phone (Primary):

Phone (Secondary):

Therapist

Name:

Medical Facility/Clinic/Program:

Address:

Phone (Primary):

Phone (Secondary):

PART 7: INTERESTS & GOALS

Please explain your interest(s) in Recovery Services at the Center:

PART 7: INTERESTS & GOALS

Please explain your recovery goals and discuss what kind of help and support you think you will need to accomplish those goals:

**PART 8: Authorization for Two-Way Release of Information for
Medical and Psychiatric Records**

1. Name of person/facility/agency other than or at Boston University to receive or release information:

2. Information I give permission to release or receive: _____

3. This release will expire on *(specify a date, time period or an event)* _____.
If nothing is specified, it will expire when I am no longer receiving services at Boston University.

I understand that I have a right to withdraw this release at any time. If I withdraw this authorization, I must do so in writing and present it to the address above. I understand that if I pull my release of this information, it will not apply to information that has already been given before I withdrew this permission.

I understand that once the above information is disclosed to a person, facility or agency outside Boston University, the person who receives this information may disclose it again and the information may not be protected by federal or state privacy laws or regulations. I understand that I may choose whether or not to sign this form and that I do not need to sign this form in order to receive rehabilitation and recovery services from Boston University and/or the other person, facility or agency. However, without the ability to share or obtain information, Boston University and/or the other person/agency may not be able to provide effective rehabilitation and recovery services.

Your Signature or Personal Representative's Signature	Date
--	-------------

Print Name of Signer

If signed by a Personal Representative:
Type of authority (e.g., court appointed, custodial parent) _____

***This form must be completed in full to be considered valid.
Distribution of copies: original to Boston University; copy to Individual or Personal Representative; copy to named person/facility/agency.*

PART 9: MEDICAL & PSYCHIATRIC INFORMATION FORM

Instructions for Part 9:

The Medical & Psychiatric Information Form on the next page (PAGE 9) needs to be completed by your primary care physician or psychiatrist, and faxed to Stephanie Cummings at (617) 353-7700.

(See Next Page for Medical & Psychiatric Information Form)



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MEDICAL & PSYCHIATRIC INFORMATION FORM

Instructions: Please fax completed form to Stephanie Cummings at (617) 353-7700.

Patient's Name:

_____ [Last] _____ [First] _____ [Middle Initial]

Physician/Psychiatrist's Name:

_____ [Last] _____ [First] _____ [Middle Initial]

Medical Facility/Clinic/Program:

Date of Last Physical Exam:

Diagnosis:

Please provide full DSM or ICD-10 Code:

Initial date of diagnosis:

Date of Last Clinical Contact:

Does patient have any physical limitations that would prevent him/her from participating in an exercise program?

Yes No

1) Weight: _____ lbs.

2) Height: _____

3) BMI: _____

Psychiatric Medication(s)

Other Medication(s)

Please List Any Restrictions/Recommendations:

Physician/Psychiatrist's Signature:

Date:
