Boston University College of Health & Rehabilitation Sciences: Sargent College
Center for Psychiatric Rehabilitation

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RECOVERY CENTER STUDENT APPLICATION

Instructions: Please complete all parts of your Student Application Packet, which can be emailed to amiras@bu.edu or faxed to (617) 353- 7700. After receiving your packet, you will be contacted before the start of the upcoming semester to arrange a tour and meeting here at the center.

PART 1: CONTACT INFORMATION

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

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

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

Phone: _____
[Cell] [Other]

Birthday: _____ Preferred Pronouns: _____
[Month] [Day] [Year] [e.g. she/her/hers]

Email: _____

* The Recovery Center uses phone, email, and text messaging to communicate with students. These are not secure modes of communication. By checking this box, you are agreeing to receiving phone calls, emails, and text messages from the Center. You are accepting and understanding the risk of having your association with the center, possibly compromised by a phone message, or with the use of unsecure email and text messages. You are also consenting to have your contact information shared with Recovery Center staff and interns, who may use it to contact you from their personal email addresses and phones.

Initials _____ Date: _____

PART 2: DEMOGRAPHIC INFORMATION

1. What is your gender identity?

- ☐ Female
- ☐ Male
- ☐ Female to male transgender (FTM)
- ☐ Male to female transgender (MTF)
- ☐ Agender
- ☐ Other (please specify): _____
- ☐ Prefer not to answer
- ☐ I don't know the answer

2. What is your race?

- ☐ Hispanic or Latino
- ☐ Black or African American
- ☐ White
- ☐ Native American or American Indian
- ☐ Asian/Pacific Islander
- ☐ Other (please specify): _____
- ☐ Prefer not to answer
- ☐ I don't know the answer

3. What is the highest degree or level of school you have completed?

- ☐ Some High School /GED
- ☐ High School Diploma/GED
- ☐ Some Undergraduate Coursework
- ☐ 2-Year College Degree (Associates)
- ☐ 4-Year College Degree (BA, BS)
- ☐ Some Graduate Coursework
- ☐ Graduate Degree (e.g. MA, MFA, PhD, MD)

4. What is your current marital status?

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

5. What is your current employment/ volunteer status?

- ☐ Employed Full-time (40+ hours per week)
- ☐ Employed Part-time (1-39 hours per week)
- ☐ Unemployed
- ☐ Volunteer Full- time (25+ hours a week)
- ☐ Volunteer Part- time (1-20 hours a week)

6. What is your current religious affiliation?

- ☐ Christianity
- ☐ Judaism
- ☐ Buddhism
- ☐ Islam
- ☐ Hinduism
- ☐ Agnosticism
- ☐ Unaffiliated
- ☐ Other (please specify): _____
- ☐ Prefer not to answer
- ☐ I don't know the answer

7. Military Status:

- ☐ No, Military Service
- ☐ National Guard
- ☐ Armed Forces
- ☐ Other (please specify): _____

8. Citizenship Status

- ☐ U.S Citizen by Birth (Native)
- ☐ Non-resident Visa type_____Exp. Date:_____
- ☐ Undocumented, in process
- ☐ U.S Citizen Naturalized
- ☐ Permanent Resident

9. What is your sexual identity?

- ☐ Heterosexual, or straight
- ☐ Homosexual – gay or lesbian
- ☐ Bisexual
- ☐ Asexual
- ☐ Fluid(ity)
- ☐ Other(please specify):_____
- ☐ I don't know the answer
- ☐ Prefer not to answer

PART 3: EMERGENCY CONTACT INFORMATION

Name:	
Relationship:	
Address:	
Phone (Primary):	Phone (Secondary):
Email:	
Name:	
Relationship:	
Address:	
Phone (Primary):	Phone (Secondary):
Email:	

PART 4: PROFESSIONAL SUPPORTS

Primary Care Physician
Name:
Medical Facility/Clinic/Program:
Address:
Phone (Primary):
Phone (Secondary):
Email:

Psychiatrist
Name:
Medical Facility/Clinic/Program:
Address:
Phone (Primary):
Phone (Secondary):
Email:

Therapist or Counselor or Case worker
Name (Primary contact):
Counseling Service:
Address:
Phone (Primary):
Phone (Secondary):
Email:

PART 5: CURRENT MEDICAL & MENTAL HEALTH CONDITIONS

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

Part 5: CURRENT MEDICAL & MENTAL HEALTH CONDITIONS

Current Mental Health Conditions	
☐ Alcohol/Substance Abuse	☐ Panic Disorder
☐ Anxiety Disorder	☐ Personality Disorder (Borderline, Antisocial, etc.)
☐ Autism Spectrum Disorder (ASD)/ Asperger's syndrome	☐ Post-Traumatic Stress Disorder (PTSD)
☐ Attention Deficit/Hyperactivity Disorder (ADHD/ADD)	☐ Schizophrenia/Schizoaffective disorder
☐ Bipolar Disorder	☐ Seasonal Affective Disorder (SAD)
☐ Depression	☐ Sexual & Paraphilic Disorder
☐ Dissociative Disorder	☐ Sleep & Wake Disorder (Insomnia, Narcolepsy, etc.)
☐ Hoarding Disorder	☐ Other:_____
☐ Illness Anxiety Disorder (IAD)	☐ Other:_____
☐ Obsessive-Compulsive Disorder (OCD)	☐ Other:_____
	☐ Other:_____
	☐ Other:_____

PART 6: ALLERGIES & MEDICATIONS

Allergies & Reactions

Current Medications

PART 7: INTEREST & GOALS

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

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

PART 8: COVID-19 Documentation

Please send COVID-19 vaccination documents by email amiras@bu.edu or fax (617-353-7700)

PART 9: 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: (insert contact relationship and name) _____

2. Information I give permission to release or receive _____

3. This release will expire on _____

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

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Amira Sheikh
Administrative Manager
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Please have your primary care physician or psychiatrist complete this form, and fax it to (617) 353-7700.

MEDICAL AND PSYCHIATRIC FORM

Patient's Full Name: D.O. B

Physician/Psychiatrist Full Name:

Medical Facility/Clinic/Program:

Date of Last Examination/Assessment:

Diagnoses:

Full DSM or ICD-10 Code(s):

Initial date of diagnosis: Date of Last Clinical Contact:

Psychiatric or Other Medication(s)

Please List Any Restrictions/Recommendations:

Physician/Psychiatrist's Signature: Date