Student Advocacy and Accountability
SOUTHEASTERN LOUISIANA UNIVERSITY
SLU 10390 | Hammond, LA 70402
Ofc: 985-549-2213 | Fax: 985-549-5103
www.southeastern.edu/osaa

Counseling Center
SOUTHEASTERN LOUISIANA UNIVERSITY
SLU 10310 | Hammond, LA 70402
Ofc: 985-549-3894 | Fax: 985-549-5007
www.southeastern.edu/admin/counseling/

COUNSELING ASSESSMENT/ TREATMENT VERIFICATION

You are required to complete an assessment at your own expense administered by a licensed mental health provider. In order to complete this sanction successfully, you must follow the steps below.

1. Choose a state accredited facility or agency by either
   a. Visiting the University Counseling Center (UCC) at no charge to students. **Please inform the UCC that an ASSESSMENT is required;** or
   b. Visit, http://www.southeastern.edu/admin/osaa/communityservices/ to select a facility or agency in the community.
2. Complete the Consent for Release of Information below for verification.
3. The assessment agency must complete the bottom portion with your results and recommendations before considered absolute.
4. Return the completed form to the Office of Student Advocacy and Accountability.
5. **Please note recommendations of the Mental Health Professional are generally incorporated into the sanctions.**

I. To Be Completed By The Student: Consent For Release Of Information For Verification

I, (print name)_____, W# (SID) _____, Southeastern Louisiana University Student, hereby authorize the exchange of information between the individual(s) listed below and Southeastern Louisiana University Office of Student Advocacy and Accountability (OSAA), the University Counseling Center (UCC) and University Conduct Authority through written, verbal or electronic means for the purpose of determining completion of a counseling assessment, receiving recommendations, and completion of treatment plan. I consent to consultation between the above-mentioned University department and/or persons and my mental health provider.

Mental Health Provider:_____

Agency:_____ **Phone**:_____

Address: _____

***_____ (Initial) I further authorize the Office of Student Advocacy and Accountability, the University Counseling Center, and University Conduct Authority to communicate about compliance with regard to attendance and participation in counseling. Content will not be disclosed unless otherwise specified.**

May your information be faxed and/or emailed? _____ Yes _____ No (Confidentiality cannot be assured through use of electronic communication such as fax and email.)

Student's Signature: _____ Date: _____

II. To Be Completed By The Licensed Mental Health Professional Or Attending Physician Conducting The Assessment

_____ 1. TREATMENT WARRANTED: Recommended # sessions: _____ Projected Date of Completion: _____/_____/_____
Month Day Year

Additional Comments: _____

_____ 2. NO TREATMENT RECOMMENDED

_____ _____ _____
Name, degree, and license type (M.D., LPC, LCSW, etc.) DEA # Date

Phone # for Verification _____ E-MAIL: _____

III. To Be Completed By The Licensed Mental Health Professional or Attending Physician Conducting Treatment

_____ Treatment requirements have been met/No additional treatment warranted at this time. **Must be released before the incident is considered CLOSED.**

Additional Comments: _____

_____/_____ _____ _____
Print name and License (M.D., LPC, LCSW, etc.) Signature DEA # Date

It is the student's responsibility to return this completed form to OSAA, Mims Hall 207, This form is proof that you have attended the treatment screening, received recommendations, and completed the treatment plan as required and will become part of your disciplinary record. Failure to follow the recommendation treatment plan will result in further disciplinary action/or a Registration Hold until obligation is satisfied.