Office of Sports Medicine

124 Keystone Hall, Sports Medicine
Kutztown, PA 19530

Office: (610) 683-4085
Fax: (610) 683-4664

Dear Health Care Provider:

Your patient, a student-athlete at Kutztown University of Pennsylvania, will be participating on one or more intercollegiate athletic teams. The National Collegiate Athletic Association (NCAA) requires all student-athletes undergo a pre-participation Mental Health Screening by a medical provider who has the professional training to perform such an exam. **This is critical for their participation in NCAA Sports.**

THIS IS AN ANNUAL REQUIREMENT FOR ALL STUDENT-ATHLETES.

Please administer, at minimum, the attached Personal Health Questionnaire-9 (PHQ-9). If there are other screening tools you feel are necessary to adequately assess the patient, please include them and their results, in addition to the PHQ-9. By completing this paper work, you acknowledge you have reviewed the patient's health history and have discussed the results of the mental health screening with the patient. Based on your professional exam, should the student-athlete require medication or mental health services for any mental health condition, please indicate this on the form provided, and provide the necessary corresponding documentation. If you require a follow-up with this student-athlete, please indicate this on the form.

Thank you for taking the time to complete this screening. We greatly appreciate your assistance as we complete the necessary NCAA requirements to ensure the mental health of our student-athletes.

Sincerely,

Sports Medicine Staff

By Postal Service to:

Attn: Athletic Physical Packet
Kutztown University of PA
Office of Sports Medicine
Keystone Hall Rm 124
Kutztown, PA 19530

Kutztown University Sports Medicine
Pre-Participation Mental Health Screening Form

As part of the NCAA's Mental Health Guidelines, every student-athlete must complete a Mental Health Screening. This must be completed annually, at a minimum. <u>This screening tool MUST be completed in the presence of a medical provider who is trained to recognize and/or treat mental health issues.</u>

NAME:______________________________ DOB:____/____/____ SPORT(S):____________________
(PRINT) Last First MI

PATIENT HEALTH QUESTIONNAIRE - 9 (PHQ-9)

Over the **<u>last 2 weeks</u>**, how often have you been bothered by any of the following problems? (Please **<u>circle</u>** your answer to each question)

		Not at all	Several Days	More than half the days	Nearly Every Day
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed, or hopeless	0	1	2	3
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself-or that you are a failure or have let yourself or others down	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9.	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Office Coding: ________ + ________ + ________ + ________.

TOTAL SCORE: ____________

If you checked off any problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people? (Please circle the amount of difficulty)

Not Difficult at all **Somewhat Difficult** **Very Difficult** **Extremely Difficult**

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission to reproduce, translate, display or distribute.

Has the individual ever received any treatment (i.e., Psychotherapy, counseling, or pharmacotherapy) ? YES _____ NO _____

<u>If yes, please explain diagnosis and provide documentation of type of treatment type, length of treatment, etc.:</u>

____

____

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<u>AFTER REVIEWING THE RESULTS OF THIS MENTAL HEALTH SCREENING TOOL WITH THE INDIVIDUAL, THE HEALTH CARE PROVIDER MUST ANSWER THE FOLLOWING QUESTIONS:</u>

Does this individual have any condition which would preclude them from participating in an intercollegiate sport? YES _____ NO _____

If yes, please explain:

____

____

Based on the score of the mental health screening tool, does the individual require any further treatment? YES _____ NO _____

<u>If yes, please circle the individual's proposed treatment plan, and provide all documentation which corresponds to the recommended treatment plan.</u>

Considering counseling, follow-up and/or pharmacotherapy **Active treatment and/or psychotherapy** **Immediate Referral**

<u>Medical Provider's Name</u>

____
(PRINT)

____
(SIGNATURE)

____
(DATE)

<u>Medical Provider's Address:</u>

____

____

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Phone: ____________________ FAX: ____________________