

CHATTANOOGA STATE COMMUNITY COLLEGE
Chattanooga, Tennessee 37406-1097

Disabilities Support Services
Paul Starnes Student Center

(423) 697-4452 (Voice/TTY)
(423) 697-2693 FAX

MEDICAL DOCUMENTATION FORM
To be filled out by Medical or Health Care Provider
(Please Print Legibly)

Student's Name: _____ D.O.B. _____

Provider Name: _____ Credentials _____

Please answer the following questions as completely as possible.

1. Are you the primary care physician for this patient? Yes No
2. How long have you treated this patient? _____
3. Date of last visit _____ Frequency of visits: _____
4. Medical diagnosis(es): **Please include DSM-IV Axis with recent GAF, if applicable:**

Diagnosis	Date of Onset:	Expected Duration: Permanent, Temporary, or, Remitting/Relapsing	Prognosis: Progressive, Stable, or Guarded

5. Has the patient been hospitalized for the above condition(s) within the past year?
 Yes No
If Yes, please specify: _____

6. What medication(s) are currently prescribed for this patient?

Medication	Dosage	Side effects experienced by patient, if applicable

7. What other medical treatment, therapies, devices, or regimens have been prescribed for this patient? _____

8. Is the patient compliant with prescribed medication and/or treatment? Yes No
 If no, please explain: _____

9. Please indicate the current functional limitation(s) of the patient: (Check all that apply)

Functional Limitation	Description	Degree of Limitation
<input type="checkbox"/> Hearing		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Vision		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Speech		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Manual		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Ambulation		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Motor Coordination		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Activities of Daily Living		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Endurance		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Respiratory		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Climatic/Environment		<input type="checkbox"/> Mild <input checked="" type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Concentration		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Memory		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Information Processing		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Social Interaction		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe

10. Please list any specific academic accommodations or other services you recommend to address the functional limitations you identified above:

11. Do you have specialty evaluations or reports (e.g., neuropsychological, psychiatric, visual, hearing, speech, physical therapy, occupational therapy, etc.) on this patient? Yes No
If yes, please include a copy.

12. Please use this additional space to provide any other information you believe will be helpful to us in assisting your patient in his/her academic endeavors at the College:

Signature

Date

Phone: _____