MEDICAL DOCUMENTATION FORM

Disabilities Support Services • 4501 Amnicola Hwy., Chattanooga, TN 37406
(423) 697-4452 (Voice/TTY) • 423) 697-2693 FAX

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**
□ Hearing		□ Mild □ Moderate □ Severe
□ Vision		□ Mild □ Moderate □Severe
□ Speech		□ Mild □ Moderate □ Severe
□ Manual		□ Mild □ Moderate □ Severe
□ Ambulation		□ Mild □ Moderate □ Severe
□ Motor Coordination		□ Mild □ Moderate □ Severe
□ Activities of Daily Living		□ Mild □ Moderate □ Severe
□ Endurance		□ Mild □ Moderate □ Severe
□ Respiratory		□ Mild □ Moderate □ Severe
□ Climatic/Environment		□ Mild x Moderate □ Severe
□ Concentration		□ Mild □ Moderate □ Severe
□ Memory		□ Mild □ Moderate □ Severe
□ Information Processing		□ Mild □ Moderate □ Severe
□ Social Interaction		□ Mild □ Moderate □ 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: _____

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