NORTHEAST STATE COMMUNITY COLLEGE

Accessibility Services
2425 Highway 75, Blountville, TN 37617
Phone: (423)279-7640

Medical Documentation Form

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

Student's Name: _____ Student's DOB: _____

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-V Axis with recent GAF if applicable)*

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

5. Has this patient been hospitalized for the above condition(s) within the past year?

   ☐ YES ☐ NO

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

Medication	**Dosage**	**Side effects experience 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 <u>current functional limitation(s)</u> 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 or Environmental		☐Mild ☐Moderate ☐Severe

Functional Limitation	Description	Degree of Limitation
☐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 their academic endeavors at the college:

    _____
    _____
    _____
    _____

Provider Signature: _____ Date: _____

Provider Phone: _____

**Please note that the student/patient is responsible for any costs pertaining to released medical or psycho-educational records.*