

# NORTHEAST STATE COMMUNITY COLLEGE

Accessibility Services  
2425 Highway 75, Blountville, TN 37617  
Phone: (423)279-7640 Fax: (423) 279-7649

## 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: <i>Permanent, Temporary, Remitting/Relapsing</i>	Prognosis: <i>Progressive, Stable, Guarded</i>

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 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 or Environmental		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe

Functional Limitation	Description	Degree of Limitation
<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:

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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:

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**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Provider Phone:** \_\_\_\_\_

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