NORTHEAST STATE COMMUNITY COLLEGE
Center for Students with Disabilities

2425 Highway 75, Blountville, TN 37617

423.279.7640 - PHONE **423.279.7649 - FAX**

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

Student's Name:_____ SS#_____ 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-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**
   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 <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
☐ **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:_____

Please note that the student/patient is responsible for any costs pertaining to released medical or psycho-educational records. NeSCC-2-13-013