Nashville State Community College

Student Disability Services Voice: (615) 353-3363 Fax: (615) 353-3770

Medical Documentation Form

To be filled out by Medical/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-5 Axis with recent GAF, if applicable:

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

5. Has the patient been hospitalized for the above condition(s) within the past year?
   _____Yes ___No
   If Yes, please specify:_____

6. What medications are currently prescribed for this patient?

Medication	Dosage	Side effects experienced by patient, if applicable

7. What other medical treatments, 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 Dexterity		**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/ 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:

Provider's Signature

Date

Provider's Address

Provider's Phone Number