Nashville State Community College

Student Disability Services   Voice: (615) 353-3721   Fax: (615) 353-3032

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-V 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 medication(s) are currently prescribed for this patient?

Medications	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:

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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 his/her academic endeavors at the College:

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______________________________ ______________________
Provider's Signature Date

______________________________ ______________________
Provider's Address Provider's Phone Number