ACCESS CENTER

Voice: 615-353-3363 | AccessCenter@nscc.edu

MEDICAL DOCUMENTATION FORM

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

Student's Name: _____ D.O.B. _____

Provider's Name: _____ Credential: _____

Please answer the following questions as completely as possible

1. Are you the primary care physician for this patient? (circle) Yes No
2. How long have you treated this patient? _____
3. Due of last visit: _____ Frequency of visits: _____
4. Medical diagnosis(es): *Please include DSM V Axis with recent GAF, if applicable*

DIAGNOSIS(ES)	DATE OF ONSET	DURATION (PERMANENT, TEMP, REMITTING/RELAPSE)	PROGNOSIS (PROGRESSIVE, STABLE, GUARDED)

5. Has the patient been hospitalized for the above condition(s) within the past year? (circle) Yes No
   a. If YES, please specify: _____
6. What medications are currently prescribed for this patient?

MEDICATION	DOSAGE	SIDE EFFECTS EXPERIENCED, IF APPLICABLE

7. What other medical treatments, therapies, devices, or regiments have been prescribed for this patient? _____
   _____
8. Is the patient compliant with prescribed medication and/or treatment? (circle) Yes No
   a. If no, please explain: _____
   _____

9. Please indicate the ***current level of 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/MOTOR COORDINATION		MILD MODERATE SEVERE
AMBULATION		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 for other services you recommend to address the functional limitations/barriers that you have identified above:

_____

_____

_____

_____.

11. Do you have specialty evaluations or reports (e.g. neuropsychological, psychiatric, visual, hearing, speech, PT/OT) on this patient? (circle) 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 Nashville State Community College:

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_____

Provider's Signature: _____ Date: _____

Provider's Address: _____ Provider's Phone: _____