Cleveland State
COMMUNITY COLLEGE
ACCESS Center
Student Center • RM 118
3535 Adkisson Drive • Cleveland, TN 37320
Phone: (423) 478-6217

Medical Documentation Form

To be completed by Medical or Health Care Provider
(Please Print Legibly)

Student's Name: _____ SSN: _____ Date: _____

Provider Name: _____ Credentials: _____

Note: Due to the nature of some medical disabilities, documentation must be within the last year. If a student returns to CSCC after a year or more absence, updated documentation is required.

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-IV or 5 Diagnosis and codes if applicable*)

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

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: _____

_____

Student Name: _____ **ID Number:** _____

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		❑ 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/Environment		❑ 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:

_____

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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 *(If yes, please attach a copy)** ❑ No

Student Name: _____ **ID Number:** _____

12. Please us 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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Signature of Diagnostician: _____

Address: _____ Phone: _____ Fax: _____

Email: _____

** If pertinent to learning issues, a current psycho-educational report may be required. Please contact the Coordinator of Disability Support Services with questions.*

*** Documentation of a disability using functional limitations should address item #9 of the Medical Documentation Form functional limitations (how the student's disability will affect his learning at school). Providers should write specific descriptions of the student's functional level in the appropriate areas and mark the degree of limitation. Recommendations for accommodations should refer specifically to the description of the functional limitation for which the accommodation is needed. For example, a functional limitation in the area of fine motor skills might have the description, "difficulty writing due to spasms from cerebral palsy." A recommendation for the student to use a digital recorder in class or be provided with a peer volunteer's class notes would be reasonable as it is supported by the description of the functional limitation.*

Please note: Disability Support Services will make the final determination in providing appropriate and reasonable accommodations.

Please return completed form to:

Counselor/Coordinator of Disability Support Services
Cleveland State Community College
3535 Adkisson Drive, P.O. Box 3570, Cleveland,TN 37320-3570
Fax: (423) 614-8724 Phone: (423) 473-2427