

PELLISSIPPI STATE TECHNICAL COMMUNITY COLLEGE  
 10915 Hardin Valley Road P.O. Box 22990  
 Knoxville, Tennessee 37933-0990

Services for Students with Disabilities

(865)539-7153  
 (865)539-7218 FAX

MEDICAL DISABILITY 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-IV Axis with recent GAF, if applicable:

Diagnosis	Date of Onset:	Expected Duration: Permanent, Temporary, or 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

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7. What other medical treatment, therapies, devices, or regiments 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)

<b>Functional Limitation</b>	<b>Description</b>	<b>Degree of Limitation</b>		
<input type="checkbox"/> Hearing (include audiogram if applicable)		<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
<input type="checkbox"/> Vision (include acuity levels if applicable)		<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
<input type="checkbox"/> Speech		<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
<input type="checkbox"/> Manual		<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
<input type="checkbox"/> Ambulation		<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
<input type="checkbox"/> Motor Coordination		<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
<input type="checkbox"/> Activities of Daily Living		<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
<input type="checkbox"/> Endurance		<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
<input type="checkbox"/> Respiratory		<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
<input type="checkbox"/> Climatic/Environment		<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
<input type="checkbox"/> Concentration		<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
<input type="checkbox"/> Memory		<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
<input type="checkbox"/> Information Processing		<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe

**Please note that the student/patient is responsible for any costs pertaining to released medical or psycho-educational records.**  
Revised January 2008

Social Interaction		Mild Moderate Severe

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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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\* If pertinent to learning issues, a current psycho-educational report may be required. Contact Director, Services for Students with Disabilities, with questions.

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

Medical or Health Care Provider Signature

Date

Phone: \_\_\_\_\_

**\*\* Documentation of a disability using functional limitations**

Documentation should address item #9 of the medical documentation form **functional limitations (how the student's disability will affect his learning at school). Recommendations for accommodations should be supported by descriptions of specific information regarding functional limitations for the categories in which the student's learning would be affected.**

Some examples include: (this is not a complete list)

How are the person's **fine motor skills** affected? Can the person write with a pen, pencil on his/her own or with a writing device (if a device is used, what is it and can student use it on his/her own)? Can the person type without an aid or do he/she use an appliance (i.e. mouth stick, pencil, special keyboard—what kind? Etc.). Will the person need someone to write for them on a quiz or test in the classroom? Will he/she need a tape recorder to record class lectures? Will he/she copies of another student's notes?

How are the person's **gross motor skills** affected? Does he/she use a wheelchair, walker, or other device? Can he/she walk or transfer from the wheelchair without assistance? Can he/she get things out of book bags by themselves, open books, turn pages without human assistance, take care of bath rooming needs, putting on/taking off clothes, etc.? If he/she needs human assistance with these tasks of a personal nature he/she should ask Vocational Rehabilitation for an assistant. The College does not accommodate tasks of a personal nature.

How is the person's **physical endurance**? How many clock hours can he/she reasonably be expected to "keep going" without a rest period? How many course hours can he/she reasonably expect to take in college? If less than full-time (12 credit hours) can Vocational Rehabilitation grant them permission to take less hours? Will the person have enough stamina to go to class, do homework, and see a tutor (if necessary)?

How is the person's **vision and hearing**? Does he/she wear glasses or hearing aids or use other devices? How is the person's **memory—long term and short term**? Does he/she have the memory skills to take several classes or should the number of classes be limited? How is the person's **respiration and breathing**?

How are the person's **verbal communication skills**? Does he/she use a speech device; write notes, use and interpreter, etc?

How is the ability to **concentrate**? Does he/she need to take tests in a less distracting environment? Does he/she need more time for tests, assignments and projects?

Providers should write specific descriptions of the student's functioning 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 tape recorder in class or be provided with a peer volunteer's class notes would be reasonable as it supported by the description of the functional limitation for concentration.

Please note: Services for Students with Disabilities will make the final determination in providing appropriate and reasonable accommodations.