Medical/ Psychological Evaluation 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 or clinician/therapist for this patient?
   YES NO

2. How long have you treated this patient? _____

3. Date of last visit: _____ Frequency of visits: _____

4. Medical or psychological 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 from 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 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 <u>current functional limitation(s)</u> 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
_____ Climate/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, share examples if applicable:

    _____
    _____
    _____
    _____
    _____

11. Do you have any 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- release provided.

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