

**Documentation of Medical Condition
Verification Form**

As the diagnosing professional, please fully complete all sections of this form. Additional reports, information, or narrative can be attached if appropriate.

Please note: All information that you provide may be shared with this student unless clearly marked otherwise. Thank you for your assistance.

I, _____, hereby authorize the release of the following information to disability Access Services at Guilford Technical Community College for the purpose of determining my eligibility for services.

Student Signature

Date of Birth

Date of Request

TO BE COMPLETED BY THE DIAGNOSING PROFESSIONAL

I. Diagnosis

Primary Diagnosis: _____

ICD-9, ICD-10 or DSM-IV Code: _____

Date of Diagnosis: _____ Date of Last Evaluation: _____

Secondary Diagnosis: _____

ICD-9, ICD-10 or DSM-IV Code: _____

Please answer these evaluation questions:

1. Please address symptoms and/or limitations imposed by the diagnosis (es) and provide a description of how the client’s medical condition is effectively or ineffectively managed.

2. Is there a periodic evaluation of the individual’s condition? Yes_____ No _____

If so, how often? _____

3. Is this medical condition and/or disability : Permanent/chronic or Permanent/acute?

4. What are the functional limitations for this individual? _____

5. List and describe any prescribed medications (including dosage) and prescribed aides (i.e. hospitalization for chronic pain management, insulin, weekly treatments, etc...) used in the treatment of this condition:

6. If the individual is taking medication, are there side effects?

7. Identify any functional limitations/restrictions that remain even with the treatment listed previously (Please be descriptive and specific. This information will help us better understand your patient's condition):

8. How does the individual's condition and/or medication affect his/her learning?

9. Recommended accommodations and/or auxiliary aids (must be clearly linked to functional limitations

Thank you for your cooperation in this matter. Your prompt attention will allow us to begin providing services as soon as possible. Incomplete or missing information can prevent or delay necessary services. This form must be completed and signed by the qualified professional who performed the evaluation and made the diagnosis.

Professional Credential Documentation (PLEASE ATTACH YOUR BUSINESS CARD TO THE DOCUMENT OR ANOTHER FORM OF IDENTIFICATION FOR THE STUDENT FILE.)

Name _____

Address _____

Title _____

Professional Credentials _____ Phone : _____

License/Certification number _____

Signature _____ Date _____

To expedite the process, you may fax a copy to (336) 819-2030. All documentation is confidential (in addition to faxing) please mail the signed, original form to: Guilford Technical Community College:

disAbility Access Services

P.O. Box 309

Jamestown, NC 27282

Attention: _____

disAbility Access Services

Creating Successful Futures