THE UNIVERSITY OF MEMPHIS
Disability Resources for Students

Disability Resources for Students

110 Wilder Tower
Memphis, Tennessee 38152-3520

Office: 901.678.2880 VOICE/TTY
Fax: 901.678.3070

www.memphis.edu

Dear Medical or Health Care Provider:

You will find a signed release at the top of the enclosed Medical Documentation form authorizing the Disability Resources for Students Office to receive medical information on your patient. This information is necessary to determine if the student has a qualifying disability which is substantially limiting in one or more daily life activities and to determine specific academic accommodations and other services the student may be eligible for while enrolled as a student at the University of Memphis.

Please complete the enclosed Medical Documentation Form and return to the address provided on the letterhead. If you have questions regarding this request, please contact me at 678-2880. Thank you for your cooperation. Your prompt reply will enable us to process this student's eligibility in a timely manner.

Sincerely,

Justin Lawhead, Interim Director
Jennifer Murchison, Assistant Director

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Release of Information:

I hereby authorize _____ to release the medical information requested herein to Disability Resources for Students at The University of Memphis for the purposes of determining my eligibility for disability related services and / or academic accommodations.

Print Name: _____ ID: _____ Date: _____

Signature: _____ DOB _____

MEDICAL DOCUMENTATION FORM
To be filled out by Medical or Health Care Provider
(Please Print Legibly)

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-TR or DSM-5 codes:

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

5. Has the patient been hospitalized for any of the above condition(s) within the past year? ☐ Yes ☑ No

If yes, please specify: _____

6. What medication(s) are currently prescribed for this patient? Please indicate below.

Medication	**Dosage**	**Side effects experienced by patient, if applicable**
Vivanse		
Loratadine		
Montelukast		
Albuterol HFA		

7. What other medical treatment, therapies, devices, or regimens have been prescribed for this patient?

none

8. Is the patient compliant with prescribed medication and/or treatment? ☐ Yes ☐ No. If No, please explain:

9. Please indicate the ***current disability related 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		☐ Mild ☐ Moderate ☐ Severe
☐ Ambulation		☐ Mild ☐ Moderate ☐ Severe
☐ Motor Coordination		☐ Mild ☐ Moderate ☐ Severe
☐ Activities ofDaily Living		☐ Mild ☐ Moderate ☐ Severe
☐ Endurance		☐ Mild ☐ Moderate ☐ Severe
☐ Respiration		☐ Mild ☐ Moderate ☐ Severe
☐ Climate/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 above:

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 University:

Physician's Signature

Date

Physician's Telephone No.