

DOCUMENTATION OF TEMPORARY CONDITION

Students requesting services for a temporary condition at NC State University must provide current documentation.

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.

Disability Services Office
Student Health Center
2815 Cates Avenue, Ste. 2221
Campus Box 7509
Raleigh, NC 27695-7509

919.515.7653 (voice)
919.513.2840 (fax)

www.ncsu.edu/dso

To Be Completed By The Student RELEASE OF INFORMATION

I, _____, hereby authorize the release of the following information to the Disability Services Office at NC State University for the purpose of determining my eligibility and services.

Student Name - Please Print

_____ Date

_____ Student's Signature

Only To Be Completed By The Diagnosing Professional

Student Name: _____

I. Diagnosis

Primary Diagnosis _____ **Code** _____
Date of Diagnosis _____ **Date of Last Evaluation** _____
What is the expected duration? _____

Secondary Diagnosis _____ **Code** _____
Date of Diagnosis _____ **Date of Last Evaluation** _____
What is the expected duration? _____

Other Diagnosis _____ **Code** _____
Date of Diagnosis _____ **Date of Last Evaluation** _____
What is the expected duration? _____

II. Treatment

Date of Last Visit: _____ **How often do you provide treatment?** _____
Other Providers and frequency? _____

Prescribed Medications

Side Effects

III. Limitations/Restrictions

List below the limitations/restrictions caused by the medical condition, how often the limitations/restrictions occur, how long they last, and the severity of each. (e.g. difficulty walking, daily, 24 hrs., moderate severity; no use of dominant hand, daily, 24 hours)

Restrictions/Difficulties

Frequency/Duration
(daily, weekly, monthly/# hours, days, etc.)

Severity
(mild, moderate, severe)

Which services, if any, do you recommend? (This is for informational purposes only. If required, NC State University will determine the appropriate services.)

Thank you for your help in providing this information so that we may 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.

Please mail the signed original form. To avoid delay, also fax us a copy to 919-513-2840.

PLEASE ATTACH YOUR BUSINESS CARD TO THE DOCUMENT OR ANOTHER FORM OF IDENTIFICATION FOR THE STUDENT FILE.

Name _____

Title _____

Business Address _____

Phone _____ Fax _____

E-Mail _____

Professional Credentials _____

License / Certification number _____

Area of Specialization _____

State / Province of Licensure / Certification _____

Signature _____ Date _____