P.O. Box 309
Jamestown, NC 27282
Phone: (336) 334-4822
(336) 454-1126
TTY: (336) 841-2158
www.gtcc.edu

Documentation of Chronic 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 disAbilityAccess 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 **1-336-232-9803**. 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: ______________________