**Diagnosis Documentation**

**To be completed *in full* by a Qualified Provider**

**Patient’s Name/DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Specific Diagnosis/Diagnoses based on ICD-10 or DSM-IV criteria (with sub-type indicated, as appropriate). Please include date of onset and last date patient seen.
2. Describe the symptoms, severity, and longevity of the condition:
3. Describe current status:
4. List medications and any side effects that may impact learning (e.g., ability to process information, etc.):
5. Describe functional limitations in an educational setting (please give specific examples):
6. Offer recommendations for accommodations:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Title/License: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Return by Email or Fax:

[StudentAccess@middlesex.mass.edu](mailto:StudentAccess@middlesex.mass.edu)

Attn: SASS at 781-275-7126

**Please refer to the documentation guidelines on our website:**

**https://www.middlesex.mass.edu/disabilityservices/documentation.aspx**