**PART II.** ***To be Completed by a medical professional***

**Submission of this form to Roanoke College does not guarantee off-campus release. Students are required to participate in housing selection unless approval is granted.**

To assist Roanoke College personnel in determining the need for housing accommodations for your patient, complete (please print) the following categories that apply to your patient. The information you provide will become a part of the student's medical record at Roanoke College.

_____
PROVIDER NAME

_____ _____
PROVIDER SIGNATURE DATE

_____
PROVIDER CREDENTIALS

_____ _____
PATIENTS'S NAME DOB

Are you the primary Specialist for this patient? _____Yes _____ No

2. Date(s) of service for this patient: _____

3. Date of most recent visit: _____

**1.** Frequency of visits in the last year: _____

## Provide the following information on *official letterhead stationery.* Complete information is required (please type).

A. Provide a complete written narrative describing the current functional limitations of the patient.
   a. Medical diagnosis including label/description with ICD 9-CM and/or DSM-IV TR Axis codes:
   b. Date of onset or initial diagnosis:
   c. Expected duration (Circle one): Permanent Temporary Remitting Relapsing
   d. Prognosis: Use descriptive qualifiers in your assessment of prognosis.
   e. Describe the student's functional limitations in a residence hall setting. Include the impact of medication or other treatments.
   f. State the degree of limitation (mild, moderate, or severe.)
   g. Explain its effects on functioning in a residence hall setting.
   h. Number of hospitalizations for the above condition(s) within the past year, **including** the length of stay:

B. Current Prescriptions:
   a. If generic, include *brand name* equivalents:
   b. Dosage instructions
   c. Patient's compliance issues, if applicable\
   d. Side effects experienced by this patient, if applicable

C. Describe any recommendations for specific housing accommodations or other services to address the functional limitations identified above.

D. Is there any other information that you believe will be helpful to us in assisting your patient in his/her residential endeavors at Roanoke College?

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

F. If you have specialty evaluations or reports (e.g. neuropsychological, psychiatric, visual, hearing, speech, physical therapy, occupational therapy, etc.), *pertinent to the residence hall environment*, for this patient include a copy or identify the service provider responsible for the evaluation or report.

G. **Medical or Health Care Provider Signature** and **Date** are required at the end of the written report.

Please note that the student/patient is responsible for any costs related to release of records.
Roanoke College Residence Life & Housing staff in conjunction with the Disability Support Services staff, and other appropriate College personnel will make the final determination in providing appropriate and reasonable accommodations for this student.