Clinician Evaluation Form

Student Name: ________________________________ Date: __________________________

Disability Student Services requires information to determine disability and eligibility for accommodations or services for the above named student. This form is provided for the convenience of physicians and/or clinicians, should they not have a standardized typed format that includes the following required information. Handwritten information is not accepted. Please contact the Office should you have any questions.

1. **Statement of Diagnosis (es) or impairment (s) and corresponding DSM-IV Code (if applicable):**

   [Blank space]

   Date of onset of medical/chronic health impairment:

   [Blank space]

   Existence of other conditions:

   [Blank space]

2. **Presenting symptoms (severity) that would significantly impact functioning in a postsecondary setting:**

   [Blank space]
Discussion on the frequency and expected duration of the symptoms:

| Statement on frequency of continued recommended services, e.g. every week, once a month, etc...: |

3. Background information including pertinent developmental, academic, and/or employment history:

| Discussion of prior accommodations in education or employment settings: |

4. Current medications including dosages, frequency, and explanation of how the medication has mitigated the student's symptoms:

| Current treatments including frequency of suggested meetings or treatments (dialysis, injections, etc...): |
Describe significant limitations to the student’s functioning related to the medication:

5. Specific recommendations for academic adjustments, auxiliary aids and/or services and rationale for each based on the student’s functional limitations:

6. Evaluator’s qualifications including name, license with state number, fax and/or phone number, email and signature:

Send to: Disability Student Services, 437 Pequot Avenue, New London, CT 06340-4498
Email: hill_c@mitchell.edu  Phone: 860-629-6137  Fax: 860-701-5790