

# General Provider Documentation Form

This form is designed to guide providers in sharing relevant information regarding the patient/client. While completing this form is not mandatory, it serves as a helpful tool to ensure that we have the information necessary to assess the student's request and determine how we can best support their disability-related needs. We encourage you to provide clear and detailed responses that address the student's diagnosed condition. If you choose not to use this form, we welcome equivalent documentation that addresses similar points. Your collaboration is invaluable in helping us create an inclusive and supportive environment for all NCCU students. Note: This form and any accompanying documentation will only be used as part of the accommodation determination process and will remain confidential as outlined in our university policies.

Please print and use the General Provider Documentation Form (PDF) if you are unable to complete the online version of the form.

**Professional's First Name**

**Professional's Last Name**

**Professional's Phone Number**

**Professional's Email**

**Professional's Occupation**

**Practice or Business Name**

**Professional's National Provider Identifier (NPI) number and/or relevant professional license numbers**

**Please select 'Yes' to indicate that you are submitting this information and documentation in accordance with and within the scope of any applicable, professional Codes of Ethics**

- \*  Yes  
 Other

**List the applicable professional body/code of ethics (For example, the American Board of Pediatrics, American Medical Board, American Psychological Association, American Counseling Association, etc.)**

**Client/Patient (the student) First and Last Name**

**Client/Patient (the student) Date of Birth**

**Client/Patient (the student) Email Address**

**Initial Meeting Date or Date Diagnosis Was Provided**

**Most Recent Meeting Date or Last Clinical Contact**

**Frequency and Number of Office Visits in the Last 12 Months**

**How did you meet with the patient/client?**

- \*  In person
- Remotely
- Both in person and remotely

**Primary Diagnosis and International Classification of Diseases/Diagnostic and Statistical Manual of Mental Disorders (ICD/DSM) Code**

\*

If the condition is temporary, how long is the impact anticipated to last?

**Second Diagnosis and ICD/DSM Code**

If the condition is temporary, how long is the impact anticipated to last?

**Third Diagnosis and ICD/DSM Code**

If the condition is temporary, how long is the impact anticipated to last?

**Other Diagnosis: Specify if it is a temporary condition as above.**

\* **Diagnostic Methodology (How did you arrive at this diagnosis?) Select all that apply**

- Clinical interview (structured or unstructured)
- Developmental history/interview(s) with other persons (e.g., parent, teacher, or therapist)
- Behavioral observation(s)
- Psychoeducational or psychological assessment (attach document)
- Medical tests (attach document)
- Other (please specify, e.g., involvement of other professionals)

Does the patient/client present issues related to any of the major life activities as listed below, and what is the severity of these impacts **without** consideration of mitigating measures (i.e., medication)?

**Allergies**

- \*  No impact (1)
- Low impact (2)
- Moderate impact (3)
- Severe impact (4)
- Not evaluated (5)

**Communication Issues**

- \*  No impact (1)
- Low impact (2)
- Moderate impact (3)
- Severe impact (4)
- Not evaluated (5)

**Focus/Concentration Issues**

- \*  No impact (1)

- Low impact (2)
- Moderate impact (3)
- Severe impact (4)
- Not evaluated (5)

**Hearing Issues**

- \*  No impact (1)
- Low impact (2)
- Moderate impact (3)
- Severe impact (4)
- Not evaluated (5)

**Learning Issues**

- \*  No impact (1)
- Low impact (2)
- Moderate impact (3)
- Severe impact (4)
- Not evaluated (5)

**Inability to Perform Manual Tasks**

- \*  No impact (1)
- Low impact (2)
- Moderate impact (3)
- Severe impact (4)
- Not evaluated (5)

**Irregularity in Appetite**

- \*  No impact (1)
- Low impact (2)
- Moderate impact (3)
- Severe impact (4)
- Not evaluated (5)

**Irregularity in Bowel Movement**

- \*  No impact (1)
- Low impact (2)
- Moderate impact (3)
- Severe impact (4)
- Not evaluated (5)

**Irregularity in Sleep Pattern**

- \*  No impact (1)
- Low impact (2)
- Moderate impact (3)
- Severe impact (4)
- Not evaluated (5)

**Memory Issues**

- \*  No impact (1)
- Low impact (2)
- Moderate impact (3)
- Severe impact (4)
- Not evaluated (5)

**Mobility Issues**

- \*  No impact (1)
- Low impact (2)

- Moderate impact (3)
- Severe impact (4)
- Not evaluated (5)

**Organization Issues**

- \*  No impact (1)
- Low impact (2)
- Moderate impact (3)
- Severe impact (4)
- Not evaluated (5)

**Procrastination Issues**

- \*  No impact (1)
- Low impact (2)
- Moderate impact (3)
- Severe impact (4)
- Not evaluated (5)

**Reading Issues**

- \*  No impact (1)
- Low impact (2)
- Moderate impact (3)
- Severe impact (4)
- Not evaluated (5)

**Spelling/Writing Issues**

- \*  No impact (1)
- Low impact (2)
- Moderate impact (3)
- Severe impact (4)
- Not evaluated (5)

**Thinking/Processing Speed Issues**

- \*  No impact (1)
- Low impact (2)
- Moderate impact (3)
- Severe impact (4)
- Not evaluated (5)

**Vision Issues**

- \*  No impact (1)
- Low impact (2)
- Moderate impact (3)
- Severe impact (4)
- Not evaluated (5)

**Spelling/Writing Issues**

- \*  No impact (1)
- Low impact (2)
- Moderate impact (3)
- Severe impact (4)
- Not evaluated (5)

**Other**

- \*  No impact (1)
- Low impact (2)
- Moderate impact (3)

Severe impact (4)

Not evaluated (5)

**Current Impact:** Please provide any additional information about the functional limitations and impacts of the disability or chronic medical condition experienced by the student along with information about the level of severity, frequency and duration of the impacts, if applicable, as they pertain to the academic and/or residential settings.

\*

**Suggested Accommodations:** Please list any tools used to reach this conclusion. Recommendations are welcomed and considered; however, the LCI Student Accessibility Center (SAC) makes the ultimate determination on eligibility and reasonable academic adjustments necessary to provide equal access for participation in academic courses, programs and activities.

\*

**Describe the link between the suggested accommodations and how they will mitigate the student/patient's symptoms/functional limitations. Recommendations should be directly linked to the impact or functional limitations associated with the disability or medication prescribed to control symptoms and include a clear rationale based on level of impairment.**

\*

**Note:** The following questions pertain to emotional support animals (ESAs). If this section is not relevant to the patient/client, please write "N/A" and submit the form.

**1. Please describe how this animal will assist the student/patient with their functional limitations.**

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**2. If you are suggesting an emotional support animal for this student/patient, please explain how you reached the determination that this animal will assist in mitigating the student's functional limitations.**

\*

**3. Having an animal on campus requires time and discipline. Have you discussed this with the student/patient? We suggest that you review with them the [NCCU Animal on Campus Regulation](#), most specifically item 7 - Responsibilities of Owners/Handlers, as they may need assistance incorporating these new tasks into their daily routine.**

\*  Yes

No

We will be addressing this in our future meetings.

An ESA is not being suggested at this time.

**4. Is there anything else you would like to add that will assist with the evaluation of the request for the student to bring an animal to reside with them on campus due to a disability need?**

\*

\_\_\_\_\_ Date

**Signature**