HARVARD MEDICAL SCHOOL

CLINICIAN REFERRAL FOR STUDENTS WITH ILLNESS/INJURY/IMPAIRMENT

STUDENT COMPLETE THE FOLLOWING:

Student (PRINT):_____Harvard ID#:_____

I authorize the clinician completing this form to release this information to the Disabilities Coordinator at Harvard Medical School for the purposes of determining my eligibility for disabilities-related services.

Student Signature:_____ Date:_____

CLINICIAN COMPLETE THE FOLLOWING:

Diagnosis:_____

The student's illness/injury/impairment effects:
☐ Mobility ☐ Vision ☐ Hearing ☐Writing ☐ Other:_____

Extent of limitations from the illness/injury/impairment:_____

_____

Estimated duration of these limitations:_____

Suggested accommodation(s):
☐ transportation assistance
☐ assistance with written work
☐ accessible classroom
☐other (specify):_____

Reevaluation is scheduled on: (Date)_____

If no follow-up evaluation is scheduled, date accommodations no longer necessary:_____

Clinician's name (PRINT):_____
Telephone number:_____

Health care facility name/location:_____

_____

Clinician's signature:_____
Date:_____

RETURN COMPLETED FORM TO:

Harvard Medical School
Student Disabilities Coordinator
25 Shattuck Street, Gordon Hall, Room-150
Boston, MA 02115
FAX: (617) 432-4308; TELEHONE: (617) 432-1575

4/98