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; TELEPHONE: (617) 432-1575

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