Accommodative Housing Committee
Center for Learning and Teaching
Accessible Education Services

ROANOKE COLLEGE

Phone: (540) 375-2247
Fax: (540) 375-2485
Email: aes@roanoke.edu

On-Campus Housing Accommodation Request

PART II. To be completed by the Diagnosing/Treating Specialist

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

Please answer the following information, with the **primary goal being to assist the Roanoke College in understanding the student's current level of functioning and need for accommodations of a disability.**

Professionals Name: _____ Title: _____

Certification or Licensure: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ Fax: _____

Email: _____

INFORMATION ON PATIENT REQUESTING SPECIAL HOUSING ACCOMMODATIONS

Patient Name: _____ DOB: _____

1. Are you the primary care physician or a specialist for this student? _____
2. Diagnosis:_____

_____

_____

3. Original date of diagnosis: _____
4. Expected duration (permanent, temporary, remitting/relapsing) _____

_____

_____

5. Prognosis (progressive, stable, guarded). Use descriptive qualifiers in your assessment of prognosis.

_____

_____

_____

6. Date(s) of service: _____

_____

7. Date of most recent visit: _____

8. Number of hospitalizations for the above condition(s) within the past year, **including** length of stay:

_____

9. Medication History: Current prescriptions, (If generic, include *brand name* equivalents) dosage, length of time on each medication, side effects, and student compliance with medications:

_____

_____

_____

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

_____

_____

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

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

1) Provide a complete written narrative describing the current functional limitations of the patient in a dormitory setting, including the impact of medication or other treatments and the degree of limitation (mild, moderate, or severe).

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

3) 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?

4) ***Provider signature and date are required*** at the end of the written report.

The Roanoke College Accommodative Housing Committee will make the final determination in providing appropriate and reasonable accommodations for this student.

Please return all materials to*:* Roanoke College, Center for Learning and Teaching. 221 College Lane, Salem, VA 24153, Attn: ***Accommodative Housing Committee***; or email to aes@roanoke.edu; or fax to 540-375-2485.