Hofstra ShieldStudent Access Services

107 Student Center

200 Hofstra University

Hempstead, NY 11549-1260

Phone: 516.463.7075

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Medical Single Documentation Form

Instructions: *This form is required for Hofstra University students who seek a housing accommodation in the form of a single room. This form is to be completed by the student’s treating physician for the relevant condition who can assess if a single room is a medically necessary (as opposed to preferential) living situation, separate and apart from learning, communication or classroom accommodations. (Please note, students diagnosed with a disability who need a distraction-free, undisturbed place to study, have various campus options available to them.)*

Student’s Name: DOB:

Hofstra ID #: Telephone #:

To be completed by the student’s trea4ng physician, NOT by a family member. All items are required. Please print legibly.

DSM-V Diagnosis Code:

Please describe symptoms/limita2ons:

Complete Diagnosis:

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With what frequency does this student experience the above limitations?

Rarely Occasionally Always

Date of Diagnosis: Email:

Date of visit: Date:

Has this student been treated in an emergency room for this condition within the last year? Has this student received in-patient treatment for this condition within the last year? Yes

Yes No No

**Circle One:**

Severity of the condition:

Mild Moderate Severe

Student is compliant with medical treatment for this condition: Rarely Sometimes Often Unknown

Please explain how symptoms functionally prohibit student from living with a roommate:

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In your medical opinion, is a single room placement is required for student’s physical/mental health (even though this may increase isolation)?

Yes No

Do you recommend any additional accommodations? (must be clearly linked to functional limitations):

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Provider signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ License/Cert#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_