Dietary Needs Requiring Accommodations: Health Care Provider Form

Health Care Provider Instructions/Form

Student Name: ___________________________  Date of Birth: ___________________________

FOR HEALTHCARE PROVIDER:
The above student is requesting dining accommodations at The George Washington University. Your professional opinion will be considered as part of the review process. Due to the vast variety of food choices available through the university’s dining program, exemptions from the university’s dining plans are extremely rare. Only those students with significant medical need(s) that cannot be met through our dining program will likely be approved. The patient listed above cannot be someone with whom you have a significant emotional and/or familial relationship (e.g., parent, sibling, or other relative).

Please provide the following information: incomplete request forms will not be considered:

• Patient’s diagnosis and related ICD-9 code________________________________________
• Date of diagnosis________________
• Current Treatment: eating plan, therapies, interventions, medications including dosage ____________________________________________________________
• Statement as to the level of severity and the activities impacted by the patient’s condition.
  __________________________________________________________
  __________________________________________________________
  __________________________________________________________
• In your professional opinion, what accommodations are required?
  __________________________________________________________
• How long has the patient been in your care and when was the last visit? ______________

You may give this completed document to the student or forward to:
The George Washington University Disability Support Services
Attn: Susan McMenamin
Address: 801 22nd St., NW Suite 102, Washington, DC 20052
Tele: 202-994-8250
Fax: 202-994-7610
Email: dss@gwu.edu

Please provide detailed information below so that you can be contacted, if necessary.

Provider Name: ___________________________

Signature_________________________________

Practice Name/Address:
  __________________________________________________________
  __________________________________________________________

Tel: __________________ Fax: ____________________

Revised: 9/1/16