SOUTHAMPTON UNIVERSITY MEDICAL EVIDENCE REQUEST

If you are unsure which route to take and therefore what evidence is required, we recommend you discuss this with Enabling Services in the first instance

REPORT REQUEST (to be completed by patient)

Why are you requesting a report?		Reasonable adjustments (including for exams) from Enabling Services ONLY
		Special Considerations (when self-certification is not possible)
		DSA application AND reasonable adjustments (including for exams) from Enabling Services (★SEE NOTE BELOW)
		DSA application ONLY (★SEE NOTE BELOW)
		Other – ***please give FULL details:***

★PLEASE NOTE: Please complete the information below (page 1 only) and attach the DSA evidence form which is available under the heading 'Proving you're eligible' at https://www.gov.uk/disabled-students-allowances-dsas/eligibility. This will be used by your doctor to provide your medical evidence.

PATIENT INFORMATION (to be completed by patient)

Name:	Telephone:	
Date of birth:	Doctor's Name:	
Address:	Name & Address of GP Practice:	
Nature of illness:	Date from:	Date to:

Please give us a brief description of impact of this illness on studies for example on memory or motivational difficulties, concentration, anxiety or paranoia, mobility, daily living, etc:

DECLARATION (to be completed by patient)

- I understand that **a fee is payable** for the medical report as this is not an NHS service. I am willing to pay the required fee.
- I **agree to the release** of medical information from records held by my GP.
- I understand that completion time for reports is **10 working days** from the date the form is received at the Surgery.
- I understand that if I wish to see the report before it is sent, **I must do so within 21 days** otherwise the report will be sent.
- I understand that a **false claim** of ill health used to influence the assessment of my University work will result in the imposition of penalties which may include termination of my programme.

Signature of student: **YOU MUST SIGN THIS BY HAND, DO NOT PROVIDE AN IMAGE OR ELECTRONIC SIGNATURE**	Date of signing:

DESTINATION (to be completed by patient)

What do you wish to happen to the completed report?	☑	(A) I wish to pick the completed report up from reception
	☐	(B) Please send the completed form to the person indicated below
If you has selected (B), please also complete the following section:		
Before your report is sent to the person below, do you wish to see it first?		I wish to see it & will do so within 21 days of completion. (It will be sent without you seeing it if 21 days elapses without you viewing.)
		I do not wish to see it. Please send it without delay to the person indicated below.
If applicable, who do you wish the report to be sent to?	Name:	
	Address:	
	Address:	
	Address:	
	Postcode:	