SOUTHAMPTON SOLENT UNIVERSITY MEDICAL EVIDENCE REQUEST

If you are unsure which route to take and therefore what evidence is required, we recommend you discuss with Student Support in the first instance.

REPORT REQUEST (to be completed by the patient)		
Why are you requesting a report?	☐	Reasonable adjustments (including for exams) from Student Support ONLY
	☐	Special Considerations (when self-certification is not possible)
	☐	DSA Application AND Reasonable adjustments (including for exams) from Student Support (❖ SEE NOTE BELOW)
	☐	DSA Application ONLY (❖ SEE NOTE BELOW)
	☐	Other – ***Please give full details***

❖ Please Note: **Please complete the information below (both pages)** 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 the patient)		
Name:	Telephone Number:	
Date of Birth:	Doctor's Name:	
Address:	Name & Address of GP Surgery:	
Nature of Illness:	Date from:	Date to:
Please give a brief description on the impact of this illness on studies for example on memory or motivational difficulties, anxiety or paranoia, mobility, daily living, etc.		

DECLARATION (to be completed by the 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 the completion time for reports is **10 working days** from the date that this 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 to the person or service named overleaf. 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 the termination of my programme.	
Signature of Student: **YOU MUST SIGN THIS BY HAND, DO NOT PROVIDE AN IMAGE OR ELECTRONIC SIGNATURE**	Date of Signature:

Please now complete the final section on page 2

DESTINATION (to be completed by the patient)		
What do you wish to happen to the completed report?	☐	(A) I wish to collect the completed report from: St Mary's Surgery ☐ Telephone House Surgery ☐
	☐	(B) Please send the completed form to the person indicated below
If you have ticked (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 the report. Please send it without delay to the person indicated below.
If applicable, who do you wish the report be sent to?	Name:	
	Address:	
	Postcode:	

As stated overleaf there is fee for the medical report which is payable on application.
Students in severe hardship can apply for financial support from the University Support Grant for this cost.

FOR SURGERY USE ONLY:

Patient Identification Provided: (please tick)

Passport ☐	Drivers Licence ☐	Identity Card: ☐
Bus Pass ☐	Other ☐	If Other, please specify:

Representative Identification Provided: (please tick)

Passport ☐	Drivers Licence ☐	Identity Card: ☐
Bus Pass ☐	Written Authorisation ☐	

Parent Identification Provided: (please tick)

Passport ☐	Drivers Licence ☐	Identity Card: ☐
Bus Pass ☐	Proof of Address ☐	If Other, please specify:

Form Completed: Yes ☐ No ☐

Fee Taken: Yes ☐ No ☐

**Print Staff Name: ……………………………………