Disability Services

Documentation requirements for Traumatic or Acquired Brain Injury

Disability Services provides academic accommodations and services to students with Traumatic or Acquired Brain Injury. Students seeking accommodations must provide relevant and comprehensive documentation of their disability so that the office of Disability Services can determine the student’s eligibility for accommodations.

Documentation should include:

1) A completed disability verification form (pages 2-4 of this document).

OR

2) If appropriate, a relevant and comprehensive adult normed psychoeducational or neuropsychological evaluation. To include: a clear statement of disability including diagnosis, test scores, clinical assessment of procedures and evaluator’s narrative.

All documentation must be submitted on the official letterhead of the professional describing the disability. The report should be dated and signed and include the name, title, and professional credentials of the evaluator, including information about license or certification. Disability Services will make the determination regarding whether accommodations are reasonable in the College environment.

All documentation is considered confidential and can be mailed or faxed to:
Disability Services
Assumption College
500 Salisbury Street
Worcester, MA 01609
Fax: (508)767-7139
Phone: (508)767-7500
Disability Verification Form: Traumatic or Acquired Brain Injury (to be completed by appropriate practitioner)

This form is intended to assist your patient in meeting the documentation requirements for requesting academic accommodations on the basis of a Traumatic or Acquired Brain Injury at Assumption College. Please fill out all of the questions on the form below. Documentation must describe a disabling condition, which is defined by the presence of significant limitations in one or more major life activities.

All information is considered confidential. Please feel free to contact Disability Services with any questions.

Student/Patient Name: __________________________________________________________

1. Please list all DSM-IV or ICD Diagnoses (text and code):
   AXIS I:
   AXIS II:
   AXIS III:
   AXIS IV:
   AXIS V
   Severity of disorder (current GAF Score) __________________________
   a. Date diagnosed: __________________
   b. Date of your last clinical contact with student: ______________

2. Evaluation
   a. How did you arrive at this diagnosis? Please check all relevant items below, adding brief notes that you think might be helpful to us as we determine eligibility for accommodations.
      Medical evaluation
      Structured or unstructured interviews with student
      Interviews with other persons (i.e. parent, teacher, therapist)
      Behavioral observations
      MRI
      Neuropsychological testing. Attach documentation
      Psychoeducational testing. Attach documentation
      Other (Please specify). ____________________________________________
   b. Evaluation Results __________________________________________________________

   c. Current treatment being received by student:
      Medication management:
      Current medications: __________________________________________


Physical/Occupational therapy
Frequency: _________________________________________
Other (please describe): ________________________________

d. Severity of symptoms:
   Mild
   Moderate
   Severe

e. Prognosis of disorder:
   Good
   Fair
   Poor

3. **Functional Limitations**
   Y □  N □  If yes, please describe: ________________________________________________
   ________________________________________________
   ________________________________________________

   a. Please describe in detail any functional limitations that fall into the significant range.
   ________________________________________________
   ________________________________________________
   ________________________________________________

   b. Please list current medications and treatment history.
   ________________________________________________
   ________________________________________________
   ________________________________________________

   c. Special considerations, e.g. medication side effects:
   ________________________________________________
   ________________________________________________
   ________________________________________________

4. **Coexisting Conditions**
   Please provide details about any coexisting psychiatric conditions.
   Please include all relevant reports.
   ________________________________________________
   ________________________________________________
   ________________________________________________

5. **Past Accommodations**
   Please mark whether student has utilized accommodations in the past. Y □  N □
   Please describe:
   ________________________________________________
   ________________________________________________
   ________________________________________________

6. **Suggested Accommodations**
   Please list the specific academic accommodations you suggest based on your assessment of the student's clinical and academic history and diagnosis.
7. (Optional) Please provide any additional information you feel will be useful in determining the nature and severity of the student’s disability, and any additional recommendations that may assist in determining appropriate accommodations and interventions:

___________________________________________________________________________________

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Thank you for your help in providing this information so that we may begin services as soon as possible. Please complete the provider information below. This form should be signed and returned to Disability Services at Assumption College, 500 Salisbury Street, Worcester, MA 01609 or by fax to (508) 767-7139.

PLEASE NOTE: To provide documentation of a TBI or ABI, the diagnosing professional must be a physician, neurologist or other medical specialist with experience and expertise in the area related to the student’s disability should make the diagnosis.

Provider Information
I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

Signature: __________________________________ Date: __________________________
Print Name and Title: __________________________________________________________
State of License: License Number: ________________________________________________
Address: _____________________________________________________________________
Street or P.O. Box City State Zip: _______________________________________________
Phone: ______________________________ Fax: ________________________________

Please return this signed form to:
Disability Services
Assumption College
500 Salisbury Street
Phone: (508) 767-7139
Fax: (508) 767-7500