CUA

THE CATHOLIC UNIVERSITY OF AMERICA
OFFICE OF DISABILITY SUPPORT SERVICES
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Disability Form To Completed by Clinical Professional

In order for us to provide disability-related services, we need to establish that this individual has a physical or mental impairment that limits one or more of the major life activities. This form is designed to help us make that determination.

Today's Date: _____

Student's Name:_____ Student's ID: _____

To Be Completed by the Student's Clinician

1) Please state the complete diagnosis:

_____

_____

2) How did you arrive at your diagnosis? Please check all relevant items below; adding brief notes that you think might be helpful to us as we determine which accommodations and services are appropriate for the student:

Structured or Unstructured interviews	□	Medical tests	□
Interviews with other persons	□	Medical History	□
Behavioral Observations	□	Developmental History	□

3) Date of Diagnosis: _____

4) This student has been under a physician's care for this issue since: _____

5) Date student was last seen: _____

6) How long is this condition likely to persist: Permanent Temporary: Date: _____

7) How often is the student required to check-in with a physician?

Once a week Once a month Every three-four months Every six months

Once a year As needed Other:_____

8) Is the student currently taking medication(s) for this issue? YES NO (see #9)
If yes, what medications is the student currently taking? For each medication, describe the side effects and any impact on academic performance. Do limitations/symptoms persist even with medications?

Medication and Dosage	Side Effects	Academic Impact	Persistence of Symptoms

9) Please explain why the student is not taking any medication.

_____

_____

_____

10) Please check which areas listed below the student is functionally limited in because of the medical diagnosis and/or the medication. Please indicate the level of limitation.

1= Unable to Determine 2= No Impact 3= Mild Impact 4= Moderate Impact 5= Substantial Impact

1	2	3	4	5	**Major Life Activities**		1	2	3	4	5	**Learning / Time Management**
					Caring for Oneself							Memory
					Talking							Concentrating
					Hearing							Listening
					Breathing							Organization
					Seeing							Managing distractions
					Walking							Timely submission of assignments
					Standing							Attending class regularly
					Lifting/Carrying							Making and keeping appointments
					Sitting							Managing stress
					Performing Manual tasks							Reading
					Eating							Writing
					Working							Spelling
					Interacting with others							Quantitative reasoning (math)
					Sleeping							Processing Speed

11) What other specific symptoms manifesting themselves at this time might affect the student's academic performance?

_____

_____

_____

12) What is the student's prognosis? How long do you anticipate that the student's academic achievement will be impacted by his/her disability?

Circle one: 6 months 1 year 1-2 years on-going permanently unknown

13) Have there been any changes in the student's condition in the past 12 months? NO YES
Please explain.

_____

_____

_____

14) Do you anticipate any changes in the student's condition/medication in the next 12 months? NO YES
Please explain.

_____

_____

_____

15) Is there anything else you think we should know about the student's medical condition?

_____

_____

_____

_____

_____

Note: Qualified diagnosing professionals are licensed physicians and surgeons, and in some instances, chiropractors. The diagnosing professional must have expertise in the differential diagnosis of the documented disorder or condition, follow established best-practices in the field, and not be related to the patient.

_____

PLEASE TYPE OR PRINT CLEARLY

Name/Title _____

Signature_____ Date: _____

License/Certification #_____ State _____

Address _____

City, State, Zip Code_____

Phone _____ Fax _____

08/2017