Student Accessibility Services

VERIFICATION OF ACQUIRED BRAIN INJURY

Student Accessibility Services provides services to students with diagnosed acquired brain injury. To determine eligibility for services, this office requires current comprehensive documentation of this disorder from a qualified diagnosing neuropsychologist, psychologist, neurologist or other licensed qualified professional currently treating the student.

Please Print Legibly

Student Name: ____________________________

Date Completed_____/_____/_______ Student’s Date of Birth_____/_____/_______

1. Disability diagnosis: __________________________________________________________

2. Date of diagnosis:_____/_____/_______

First contact with student_____/_____/_______ Last contact with student:_____/_____/_______

3. In addition to DSM 5 criteria, how did you arrive at your diagnosis?

☐ Structured or unstructured clinical interviews with the individual
☐ Interviews with other individuals
☐ Behavioral observations
☐ Developmental history
☐ Educational history
☐ Medical history
☐ Neuro-psychological testing – Date: ___________
☐ Psycho-educational testing – Date: ___________
☐ Standardized or non-standardized rating scales
☐ Other (please specify): ___________________________

4. What is the severity of the disability? Please check one:

☐ Mild ☐ Moderate ☐ Severe

Explain Severity: ____________________________________________________________

__________________________________________________________

5. What is the expected duration of this disability? ________________________________

   _____________________________________________________________
6. Please list and describe the major life activities/functional limitations that are significantly impacted by the disability and degree of severity. Please note if not major life activities are not significantly impacted, no accommodations may be considered.

___________________________________________________________________________________

___________________________________________________________________________________

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___________________________________________________________________________________

7. Is the student currently receiving rehabilitation, therapy or counseling services? ☐ Yes ☐ No

___________________________________________________________________________________

8. What medication(s) is the student currently taking? How effective is the medication? How might side effects, if any, affect the student’s academic performance?

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

9. Describe any situation or environmental conditions that might lead to an exacerbation of the condition.

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

10. State specific recommendations regarding academic accommodations for this student, and the rationale as to why these accommodations/services are warranted based upon the student’s functional limitation. Indicate why the accommodations are necessary.

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___________________________________________________________________________________
11. If any co-morbid conditions exist, please describe.

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Provider Information

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Medical Specialty:</td>
<td>License #:</td>
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<tr>
<td>Address:</td>
<td></td>
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<tr>
<td>Phone:</td>
<td>Email:</td>
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<tr>
<td>Clinician’s Signature:</td>
<td>Printed Name:</td>
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</tbody>
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Please mail or fax this completed form and any additional information to:

Student Accessibility Services       920-465-2841
UW-Green Bay                         FAX 920-465-2191
2420 Nicolet Drive, SS 1700           EMAIL: SAS@UWGB.EDU
Green Bay, WI 54311