DOCUMENTATION OF DISABILITY FORM TO BE COMPLETED BY THE DIAGNOSING CLINICIAN

Bon Secours Memorial College of Nursing | Southside College of Health Sciences | St. Mary's Hospital School of Medical Imaging

Center for Student Success, Student Access and Accommodation Services

C O N F I D E N T I A L

1. **Student's Name: _____Today's Date: _____**
2. **Diagnostic Information**
   a. DSM-V Diagnosis: Primary: _____
      Secondary: _____
   b. Date of Diagnosis: _____Full Title of Diagnosis: _____
   c. DSM-V Diagnosis: Primary: _____
      Secondary: _____
   d. Date of Diagnosis: _____Full Title of Diagnosis: _____

   Please include all records relating to the diagnoses above. For informal assessments or observations, include a note on professional letter head detailing the diagnostic process as it pertains to the student.

3. **Contact History**
   a. This student has been under a provider's care for this issue since: _____
   b. Date student was last seen: _____

4. **Impact of Condition**
   a. How long is this condition likely to persist? (Permanent/Temporary) _____

   b. How often is the student required to check-in with a provider?
      Once a week Once a month Every 3-4 months Every 6 months
      Once a year As needed Other: _____

   c. Is the student currently taking medication(s) for their symptoms *(please circle answer)?*
      YES NO
      If yes, what medication(s) is the student currently taking? For each medication, describe the side effects any impact on academic performance, and limitations/symptoms persisting.
      Please print clearly:

Medication and Dosage	Side Effects	Academic Impact	Symptoms Persist with Medication?

d. Please note to what extent each of the following life activities, learning/time management are affected due to the diagnosis.

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

Life Activities					
	1	2	3	4	5
Hearing					
Standing					
Lifting/Carrying					
Sitting					
Sleeping					
Learning/Time Management					
Reading					
Writing: spelling					
Math (quantitative reasoning)					
Processing speed					
Stress Management					
Listening					
Concentration					
Managing distractions					
Memory					
Planning/Organization					
Time Management					
Attending classes regularly					
Timely submission of assignments					

e. What other specific symptoms manifesting themselves at this time might affect the student's ability to access the College of Nursing programming, facilities, and/or academic opportunities?

_____

_____

f. What is the student's prognosis? How long do you anticipate that the student's ability to access the College of Nursing programming, facilities, and/or academic opportunities will be impacted by their disability/condition?

_____

_____

g. Have there been any changes in the student's condition in the past 12 months (please circle answer)?

YES (please explain below) **NO**

_____

_____

h. Do you anticipate any changes in the student's condition in the next 12 months(please circle answer)?

YES (please explain below) **NO**

_____

_____

i. Is there anything else you think we should know about the student's medical condition and their ability to function academically and/or socially in a college environment?

_____

_____

5. **Recommendations by the Diagnosing Clinician**

Describe any barriers the student may face due to their disability when accessing academic settings:

_____
_____
_____

ACCOMMODATIONS:

Please note any accommodations you recommend due to the student's disability. Please also describe why you're recommending this accommodation for the student, and how it will support the student's equal access of our campus.

Recommended accommodation	**Description of how this accommodation will support the student's equal access**

6. **Credentials and Signature** (please type or print clearly)

Clinician's Name: _____

Professional Qualifications: _____

Address, City, State, Zip: _____

Phone Number: _____Fax Number: _____

Email: _____License/Cert. Number: _____

Clinician's Signature: _____

Should we need to confirm this information with you, please note your best method of contact:

_____

Thank you for your time and consideration in the completion of this documentation. This form and any additional records will be confidentially kept in accordance with the Family Educational Rights and Privacy Act (FERPA). Send any/all additional documentation on professional letterhead to: (prefer email/scan)

CONFIDENTIAL
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