Acquired Brain Injury Documentation Instructions and Form
Updated March 2024

Student Instructions and Information:

- Students must submit current documentation to the Office of Accessibility and Testing Services. Impairments following an acquired brain injury may change rapidly in the weeks and months after the injury. A stable picture of residual weaknesses may not be apparent for 1-2 years after an injury. Documentation should reflect data collected within a month at the time of request for services. Less recent documentation may be submitted for review, but may not be accepted if it fails to adequately indicate current functioning.
- A qualified provider (medical doctor, psychologist or psychiatrist) must provide the documentation.
- In place of this form, a letter may be provided including all of the requested information. Any letters must be on letterhead from the provider’s practice. Any documentation must include the provider’s signature and credentials.
- Students are encouraged to provide documentation prior to the intake meeting if at all possible. It is during the intake meeting that appropriate accommodations, and the process for using the accommodations, will be discussed. Based on the student’s individual situation, it will be determined when updated documentation will be required in order to continue providing the most appropriate accommodations.
- For timely review of application, documentation must be submitted by the student requesting services via our secure portal, AIM located on our website. If you have any questions regarding this process, please email to accessibility-services@westga.edu.

To be Completed by Student:

Name (Last, First, Middle):__________________________________________________________

Date of Birth: ________________________________ UWG ID Number: 917___________________________

Cell Phone: ________________________________ Alternate Phone: ________________________________

Home Address: _____________________________________________________________________________
________________________________________________________________________________________

Email Address: _____________________________________________________________________________

Status (Check One): _____Current Student _____ Transfer Student _____ Prospective Student
To be Completed by Provider:

The Office of Accessibility and Testing Services establishes academic and/or housing accommodations for students with a documented disability. The Americans with Disabilities Act (ADA) defines a disability as a physical or mental impairment that substantially limits one or more major life activities. The University System of Georgia Board of Regents (USGBOR) requires current and comprehensive documentation for any diagnosis of a disability in order for disability services providers to determine appropriate accommodations and services. Please see Appendices D-H of the USGBOR Academic and Student Affairs Handbook for more information.

Please provide the date or period of time of the brain injury, as well as the nature of the neurological illness or traumatic event that resulted in the brain injury.

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

If a DSM-5 diagnosis is appropriate, please complete the following:

Primary Diagnosis:__________________________________________________________________________

DSM-5 Code:___________________________________Date of Diagnosis:____________________________

Secondary Diagnosis:________________________________________________________________________

DSM-5 Code:___________________________________Date of Diagnosis:____________________________

Please provide the diagnostic criteria and methodology used to diagnose the condition.

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Is it expected that the patient’s functioning and/or severity of the impact of the injury will change over time?

_____Yes  _____No

If yes, please explain the anticipated progression.

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
Please explain the current functional limitations. **The functional impact of the brain injury must be documented by appropriate, objective measures (e.g. cognitive and academic skills, psychosocial-emotional functioning, and/or sensory abilities) relevant to the academic environment.** Attach additional documentation to fully document the limitations as appropriate.

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

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________________________________________________________________________________________

Please provide any recommendations to address the indicated functional limitations.

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

**Please attach any psychological and/or educational reports that support the functional impact of the brain injury** and complete the following information:

Provider Name:_____________________________________________________________________________

Title:_____________________________________________________________________________________

License #:_________________________________________________________________________________

Practice Name and Address:___________________________________________________________________

________________________________________________________________________________________

Phone:________________________________________Fax:________________________________________

Email:____________________________________________________________________________________

Provider Signature **(REQUIRED)**:_____________________________________________________________

Date of Signature:___________________________________________________________________________