

## Acquired Brain Injury Documentation Instructions and Form

Updated December, 2015

### Student Instructions and Information:

- Students must submit **current** documentation to Accessibility 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 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 asked 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.**
- Documentation can be submitted in person or by mail to the UWG Counseling Center, 123 Row Hall, Carrollton, GA 30118, by fax to 678-839-6429, or by email to [counseling@westga.edu](mailto:counseling@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 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.**

---

---

---

---

---

---

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: \_\_\_\_\_