Medical and Mobility (Systemic/Visual) Disorders Documentation Instructions and Form
Updated December, 2015

Student Instructions and Information:

- Students must submit current documentation to Accessibility Services.
  - Current documentation is defined as:
    - Documentation that reflects data collected within three years at the time of request for services UNLESS the condition is of a permanent and non-varying nature. If additional accommodations are requested due to changes in functional limitations, updated documentation may be requested.
    - It is at the Accessibility Services counselor’s discretion to make appropriate exceptions to this policy and/or to request a reevaluation and more recent documentation in order to establish the most appropriate accommodations.
- A qualified provider (medical doctor) 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.
- 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.

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.

Primary Diagnosis:________________________________________________________________________

DSM-5/ICD-10 Code:___________________________________Date of Diagnosis:______________________

Secondary Diagnosis:________________________________________________________________________

DSM-5/ICD-10 Code:___________________________________Date of Diagnosis:______________________

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

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Please describe the history and severity of the disorder.

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

_____Yes  _____No
If yes, please explain the anticipated progression.

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__________________________________________________________________________________________
__________________________________________________________________________________________

Please check all of the following as appropriate to describe the patient’s functional limitations.

____ Use of a wheelchair or scooter to aid mobility
____ Limited stamina
____ Fatigue
____ Headaches accompanied by nausea, vomiting, and/or sensitivity to light and sound
____ Limited upper body mobility, trouble grasping, handling objects
____ Lack of muscle control and balance
____ Poor coordination
____ Limited ability or unable to write/keyboard
____ Affected speech
____ Bowel and/or bladder incontinence
____ Pain
____ Low tolerance for temperature changes/extremes
____ Problems being exposed to fumes/dust/mold/gasses, etc.
____ Trouble with focus and concentration
____ Breathing difficulties
____ Problems with depression or mood swings
____ Difficulty reading
____ Limited space, form, and/or depth perception
____ Field of vision deficit
____ Medication side effects

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Other
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Other
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Other
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Please provide any additional information/context as appropriate concerning the functional limitations.

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Please provide any recommendations to address the indicated functional limitations.

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Please attach any psychological and/or educational reports that support the diagnosis and associated functional impact and complete the following information:

Provider Name:_____________________________________________________________________________
Title:_____________________________________________________________________________________
License #:_________________________________________________________________________________
Practice Name and Address:___________________________________________________________________

Phone:________________________________________ Fax:________________________________________
Email:____________________________________________________________________________________

Provider Signature (REQUIRED):____________________________________________________________________
Date of Signature:___________________________________________________________________________