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.

_____

_____

_____

_____

_____

_____

Please describe the history and severity of the disorder.

_____

_____

_____

_____

_____

_____

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.

_____

_____

_____

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_____
_____
_____

_____Other_____
_____

_____Other_____
_____

_____Other_____
_____

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

_____

_____

Please provide any recommendations to address the indicated functional limitations.

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:_____