Acquired Brain Injury Documentation Instructions and Form
Updated January 2023

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 Accessibility Services, 123 Row Hall, Carrollton, GA 30118, by fax to 678-839-6429, or by 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 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:________________________________________________________________________