DISABILITY AND ACCESS

THE UNIVERSITY OF TEXAS AT AUSTIN

*100 West Dean Keeton St. A4100 · Austin, TX 78712-1093*
*disability.utexas.edu · (512) 471-6259 · FAX (512) 475-7730 · VP (512) 410-6644*

# Disability and Access
# Verification Form for Students with Physical or Medical Disabilities

This form is intended to assist in meeting our documentation requirements for these disabilities. However, if not thoroughly completed, it may not be sufficient as the sole form of documentation provided. Please refer to the "Guidelines for Documenting Physical or Medical Disabilities" for comprehensive documentation requirements and additional information. To ensure the provision of reasonable and appropriate accommodations, students requesting services must provide current documentation of the disability. The age of acceptable documentation is dependent upon the condition and the nature of the student's request for accommodations. Disabilities that are sporadic or change over time may require more frequent evaluations. Documentation that reflects the *current* impact on the student's functioning should be submitted. Present symptoms that meet the criteria for the diagnosis must be noted. This documentation should provide information regarding the onset, longevity and severity of symptoms, as well as the specifics describing how it has interfered with educational achievement. To standardize our gathering of information, we ask that you complete the following questions, even if the material has already been included in your evaluation. *The provider completing this form cannot be a relative of the student.* All information will be kept confidential. Please feel free to contact D&A at (512) 471-6259 with questions.

***The information below is to be completed and signed by the student.***

I request and authorize The University of Texas at Austin University Health Services (UHS), Counseling & Mental Health Center (CMHC), Disability and Access and/or my off-campus provider (name)_____ to release, fax, mail or discuss with each other information related to my registering with Disability and Access (D&A).

_____

Student Name EID

_____

Student Signature Date

Email Address: _____ Phone Number: _____

*If the information above is left blank or is incomplete it may delay or prevent D&A from contacting the student to verify receipt of the documentation and provide next steps for completing the registration process.*

***The information below is to be completed and signed by the Provider.***

***1. Diagnosis:*** Please list all relevant diagnoses.

_____

_____

a. Approximate onset of diagnosis

- Child-approximate age:_____
- Adolescent-approximate age:_____
- Adult-approximate age:_____
- Unknown

b. Date of your last clinical contact with student: _____/_____/_____

***2. Evaluation***

a. How did you arrive at this diagnosis? Please check all relevant items below, adding brief notes that you think might be helpful to us as we determine eligibility for accommodations.

- Medical evaluation (x-ray, lab work, EKG, etc.)
- Structured or unstructured interviews with student.
- Interviews with other persons (i.e. parent, teacher, therapist).
- Behavioral observations.
- Neuropsychological testing. Attach documentation.
- Psychoeducational testing. Attach documentation.
- Other (Please specify). _____

b. Evaluation Results: _____

_____

c. Present symptoms that meet criteria for diagnosis being noted:

_____

_____

d. Current treatment being received by student:

- Medication management:

  Current medications: _____
- Physical / Occupational therapy

  Frequency: _____
- Other (please describe):

  _____

e. Severity of symptoms
   - Mild
   - Moderate
   - Severe

f. Prognosis of disorder:
   - good
   - fair
   - poor

g. ***Functional Limitations***: *Should be determined WITHOUT consideration of mitigating measures (i.e. medication, etc.). If condition is episodic in nature, level of functioning should be assessed based on active phase of symptoms.*

a. Does this condition significantly **limit one or more of the following major life activities**?

| | No Impact | Moderate Impact | Substantial Impact | Don't Know |
|---|---|---|---|---|
| Communicating | | | | |
| Concentrating | | | | |
| Hearing | | | | |
| Learning | | | | |
| Manual Tasks | | | | |
| Reading | | | | |
| Seeing | | | | |
| Thinking | | | | |
| Walking | | | | |
| Working | | | | |
| Other: | | | | |

b. Please check the **functional limitations or behavioral manifestations** for this student:

| | Not an Issue | Moderate Issue | Substantial Issue | Don't Know |
|---|---|---|---|---|
| Cognitive Processing | | | | |
| Memory | | | | |
| Processing Speed | | | | |
| Meeting Deadlines | | | | |
| Attending class | | | | |
| Organization | | | | |
| Reasoning | | | | |
| Stress | | | | |
| Sleep | | | | |
| Appetite | | | | |
| Other: | | | | |
| Other: | | | | |

c. Please describe in detail any functional limitations that fall into the substantial range.

_____

_____

d. Special considerations, e.g. medication side effects: _____

_____

_____

e. ***COURSE LOAD REDUCTION***: Is the student's condition such that it may require them to drop a course and/or take fewer than what is considered a full-time course load?

- Yes
- No
- I don't know

If YES please explain:_____

_____

_____

***4. Accommodations***

a. Please mark whether student has utilized accommodations in the past.

- Yes- Please describe:_____
- No
- Don't Know

b. (Optional) Recommended educational accommodations:

_____

_____

c. (Optional) Please provide any additional information you feel will be useful in determining the nature and severity of the student's disability, and any additional recommendations that may assist in determining appropriate accommodations and interventions:

_____

_____

*Thank you for your help in providing this information so that we may begin services as soon as possible. Please complete the provider information on the next page. This form should be signed and returned via fax or mail to the D&A office at the address shown at the end of this document.*

***All documentation submitted to D&A is considered confidential.***

***Provider Information***

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

Signature: _____ Date: _____

Print Name and Title: _____

_____

State of License: _____ License Number: _____

Address _____

_____

Street or P.O. Box City State Zip

Phone:_____ Fax:_____

**Please return this form to:**

The University of Texas at Austin
Division of Student Affairs
Disability and Access
100 W. Dean Keeton St. Stop A4100
Austin, TX 78712-1093
Phone: (512) 471-6259
Email: access@austin.utexas.edu
Fax: (512) 475-7730
VP (512) 410-6644

***Attach Provider Business Card Here***