Boston University Disability & Access Services

Disability Verification Form – Mild Traumatic Brain Injury (mTBI)

The Disability & Access Services provides academic accommodations and services to students with Mild Traumatic Brain Injury (mTBI). Students seeking accommodations must provide appropriate documentation of their disability so that Disability & Access Services can determine the student's eligibility for accommodations and academic accommodations. mTBI is accommodated as a temporary disability based on your assessment of severity, duration and prognosis of the current condition.

The Disability & Access Services requests the following current documentation from a qualified professional with experience and expertise in the area related to the student's disability:

Documentation should include:

- A current written report not older than 6 months including all relevant symptoms, diagnosis and time course of condition. Documentation should also note the status of the individual's impairment (remitting, static or progressive)
- Written summary of assessment procedures that were used to make the diagnosis, evaluation results, and history of condition
- Detailed statement of the *current* impact on the student's functioning and description of how current functional limitations will present in an academic environment.
- Specific recommendations for accommodations based on objective findings of functional limitations
- If relevant, a current cognitive and/or neuropsychological evaluation may be submitted
- The diagnostic report must include the *name and title, and license number* of the evaluator.
- A complete Disability Verification Form (please do not write "see attached")

Further assessment by an appropriate professional may be required if co-existing psychological, medical, physical or learning disabilities are indicated. All documentation must be submitted on the official letterhead of the professional describing the disability. The report should be dated and signed and include the name, title, and professional credentials of the evaluator, including information about license or certification. ODS will make the determination regarding whether accommodations are reasonable in the University environment.

All documentation is considered confidential and can be mailed or faxed to:

Disability & Access Services
25 Buick Street Suite 300
Boston, MA 02215

Phone: 617-353-3658

Fax: 617-353-9646
access@bu.edu
www.bu.edu/disability

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Disability Verification Form – Mild Traumatic Brain Injury (mTBI)

This form is intended to assist your client in meeting the documentation requirements for requesting academic accommodations on the basis of a **Mild Traumatic Brain Injury (mTBI)** at Boston University. Please fill out all of the questions on the below form, even if the material has been included in your full evaluation and/or clinical summary. The documentation must describe a disabling condition, which is defined by the presence of significant limitations in one or more major life activities.

This documentation should provide information regarding the **severity**, **duration** and **prognosis**, of symptoms, as well as the specifics describing how it has interfered with educational achievement. Please include a copy of all assessments used in making diagnosis.

*Most students with mTBI will be accommodated as students with **temporary disabilities**. Accommodations are based on an individualized determination of need. Therefore your thoughtful assessment of the most important symptoms and domains of impairment will be the most useful in determining how to best serve your patient.*

All information will be kept confidential. Please feel free to contact Disability & Access Services at (617) 353-3658 with any questions.

For the student to complete:

Signed:_____Date:_____

Name: (please print)_____ BU ID:_____

For the current diagnostician or treating healthcare provider to complete:

1. Diagnosis: Please list all relevant diagnoses and ICD Code:

_____

_____

a. Date(s) of Injury: _____
b. Date of Assessment: _____
c. Date of last clinical contact with student: _____

2. Evaluation

a. How did you arrive at this diagnosis?

- ☐ Medical evaluation
- ☐ Structured or unstructured interviews with student.
- ☐ Interviews with other persons (i.e. parent, teacher, coach).

☐ Behavioral observations.

Current Symptom	0 None	1 Mild	2 Moderate	3 Severe
Photosensitivity				
Cognitive Fatigue				
Visual Fatigue				
Attention/Concentration				
Memory and Learning (encoding and retention of new information)				
Memory (recall/retrieval)				
Neurobehavioral Symptoms (impulse control/ irritability/mood)				
Noise Sensitivity				
Physical Symptoms (headache, nausea, dizziness)				
Problem Solving				
Rate of Information Processing				
Motor or Sensory Symptoms				
Other				

☐ Diagnostic Imaging (CT, EEG, MRI, other)
☐ Neuropsychological or cognitive testing. Attach documentation.
☐ Psychological testing. Attach documentation.
☐ Other exam: Specify _____

b. Current Symptom Checklist. Please indicate all relevant symptoms and rate **current** severity:

c. **Overall Severity** of symptoms:
☐ Mild
☐ Moderate
☐ Severe

d. **Prognosis of disorder**:
☐ Excellent
☐ Good/Fair
☐ Poor

d. **Duration of disorder**:
☐ 1-3 months
☐ 3-6 months
☐ 6-12 months
☐ 12-long-term

f. **Current treatment plan**:
☐ Medication management:
Current medications: _____
Side effects if present: _____
☐ Physical/Occupational/Speech/Cognitive therapy
Frequency: _____
☐ Other (please describe): _____

3. Functional Limitation Checklist:

Please indicate all that apply and rate severity below:.

Functional Impairment	0 No impairment	1 Mild impairment	2 Moderate impairment	3 Severe impairment
Reading/Studying				
Organization				
Test taking				
Computer use				
Attendance				
Papers/Projects				
In Class Presentations/ Participation				
Other (e.g. labs, group work, field trips)				

a. Please describe in detail any functional limitations that fall into the ***very significant range***.

_____
_____
_____

c. Special considerations, e.g. physical or motor symptoms, medication side effects:

_____
_____
_____

4. Coexisting Conditions

Please provide details about any coexisting psychiatric or medical conditions.
Please include all relevant reports.

_____
_____
_____

_____

6. Accommodation Recommendation Checklist: Please select recommended accommodations based on your assessment of the student's current clinical symptoms and related functional impairments. ***Please note that selecting all will not be helpful in determining the best plan for your patient.***

Suggested Accommodations:	Rationale:
Attendance flexibility	
Reschedule exams	
Extensions for projects or papers	

Physical Rest	
Cognitive rest: please define scope	
Brief Breaks During exams	
Part Time Status/taking fewer classes	
Lower Lightening During exams	
Assistive Technology	
Note Taker	
Extra time on exams	
Brief Breaks during exams	
Other:	
Comments:	

7. (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 below. This form should be signed and returned to Disability & Access Services at the address shown at the end of this document.

PLEASE NOTE: To provide documentation of a TBI the diagnosing professional must be a physician, neurologist or other medical specialist with experience and expertise in the area related to the student's disability should make the diagnosis.

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 signed form to:

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Boston, MA 02215
Phone: 617-353-3658
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