



UNIVERSITY of WISCONSIN
GREEN BAY

Student Accessibility Services

VERIFICATION OF ACQUIRED BRAIN INJURY

Student Accessibility Services provides services to students with diagnosed acquired brain injury. To determine eligibility for services, this office requires **current comprehensive documentation** of this disorder from a qualified diagnosing **neuropsychologist, psychologist, neurologist or other licensed qualified professional currently treating the student.**

Please Print Legibly

Student Name: _____

Date Completed ____/____/____ Student's Date of Birth ____/____/____

1. Disability diagnosis: _____

2. Date of diagnosis: ____/____/____

First contact with student ____/____/____ Last contact with student: ____/____/____

3. In addition to DSM 5 criteria, how did you arrive at your diagnosis?

- Structured or unstructured clinical interviews with the individual
- Interviews with other individuals
- Behavioral observations
- Developmental history
- Educational history
- Medical history
- Neuro-psychological testing – Date: _____
- Psycho-educational testing – Date: _____
- Standardized or non-standardized rating scales
- Other (please specify): _____

4. What is the severity of the disability? Please check one:

- Mild Moderate Severe

Explain Severity: _____

5. What is the expected duration of this disability? _____

6. Please list and describe the major life activities/functional limitations that are significantly impacted by the disability and degree of severity. ***Please note if not major life activities are not significantly impacted, no accommodations may be considered.***

7. Is the student currently receiving rehabilitation, therapy or counseling services? Yes No

8. What medication(s) is the student currently taking? How effective is the medication? How might side effects, if any, affect the student's academic performance?

9. Describe any situation or environmental conditions that might lead to an exacerbation of the condition.

10. State specific recommendations regarding academic accommodations for this student, and the rationale as to why these accommodations/services are warranted based upon the student's functional limitation. Indicate why the accommodations are necessary.

11. If any co-morbid conditions exist, please describe.

Provider Information

Name:		Date:	
Medical Specialty:		License #:	
Address:			
Phone:		Email:	
Clinician's Signature:		Printed Name:	

Please mail or fax this completed form and any additional information to:

Student Accessibility Services
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