The Office of The Office of Disability Services (ODS) provides academic accommodations and services to students with **Traumatic Brain Injury (TBI)**. Students seeking accommodations must provide appropriate documentation of their disability so that ODS can determine the student’s eligibility for accommodations; and if the student is eligible, determine appropriate academic accommodations. The documentation must describe a disabling condition, which is defined by the presence of significant limitations in one or more major life activities.

To verify the disability and its severity, ODS requests the following current documentation from an ophthalmologist, optometrist or other qualified professional with experience and expertise in the area related to the student’s disability should make the diagnosis.

Documentation should include:

- A **current** clear statement of disability including **diagnosis**. Current documentation is dependent upon the student’s condition and the nature of the student’s request for accommodations. Documentation should also note the status of the individual’s impairment (static or progressive).
- 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 present and noted.
- If relevant, a comprehensive **psychoeducational** or **neuropsychological** evaluation not be more than three years old and must be based on adult normed testing. The Wechsler Adult Intelligence Scale-III (WAIS-IV) is preferred.
- A narrative **clinical summary** of assessment procedures that were used to make the diagnosis, evaluation results, history of disability and list any recommended accommodations.
- A description of how current functional limitations will present in an academic environment.
- Suggested Accommodations to address each limitation.
- 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 learning disabilities or other disabling conditions 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:**
Office of Disability Services  
19 Deerfield St, second floor  
Boston, MA  02215  
Phone: 617-353-3658  
Fax: 617-353-9646  
access@bu.edu  
www.bu.edu/disability
This form is intended to assist your client in meeting the documentation requirements for requesting academic accommodations on the basis of a **Traumatic Brain Injury (TBI)** 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.

To ensure the provision of reasonable and appropriate accommodations, students requesting academic accommodations must provide current documentation of their disability. Current documentation is dependent upon the student’s condition and the nature of the student’s request for accommodations. It should also note the status of the individual’s impairment (static or progressive); a changing nature of functionality may need to be documented more frequently.

This documentation should provide information regarding the **severity, duration** and **pervasiveness**, 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.

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

**Student name:**
Signed: __________________________ Date: __________________________
Name: (please print) __________________________ BU ID: __________________________

**For the current treating healthcare provider to complete:**

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

   __________________________________________
   __________________________________________
   __________________________________________

   a. Approximate onset of diagnosis
   o Child- approximate age: ______________
   o Adolescent – approximate age: ______________
   o Adult-approximate age: ______________

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

2. **Evaluation**
   a. How did you arrive at this diagnosis?
   o Medical evaluation
   o Structured or unstructured interviews with student.
   o Interviews with other persons (i.e. parent, teacher, therapist).
   o Behavioral observations.
   o MRI
   o Neuropsychological testing. Attach documentation.
   o Psychoeducational testing. Attach documentation.
   o Other exam: Specify __________________________________________
b. Evaluation Results
______________________________________________________________
______________________________________________________________
c. Current treatment being received by student:
o Medication management:
  Current medications: ____________________________________________
o Physical/Occupational therapy
  Frequency: ___________________________________________________
o Other (please describe): ________________________________________
d. Severity of symptoms:
o Mild
o Moderate
o Severe
e. Prognosis of disorder:
o Good
o Fair
o Poor

3. Functional Limitations  Y ☐  N ☐ If yes, please describe: __________________________________________________________
______________________________________________________________
______________________________________________________________
a. Please describe in detail any functional limitations that fall into the significant range.
____________________________________________________________________________________
b. Please list current medications and treatment history.
____________________________________________________________________________________
c. Special considerations, e.g. medication side effects:
____________________________________________________________________________________
____________________________________________________________________________________

4. Coexisting Conditions
Please provide details about any coexisting psychiatric conditions.
Please include all relevant reports.
____________________________________________________________________________________
____________________________________________________________________________________

5. Past Accommodations
Please mark whether student has utilized accommodations in the past. Y ☐  N ☐
 Please describe: ____________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
6. **Suggested Accommodations**

Please list the specific academic accommodations you suggest based on your assessment of the students clinical and academic history and diagnosis.

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

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 ODS 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.

If filling out online, in lieu of signature, please click here to certify that the above statement is true.

Y ☐ N ☐

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:**

Office of Disability Services,
19 Deerfield St, second floor
Boston, MA 02215
Phone: 617-353-3658
Fax: 617-353-9646