The Office of Disability Services (ODS) 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 ODS 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.

ODS 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:**

Office of Disability Services  
25 Buick Street Suite 300  
Boston, MA 02215  
Phone: 617-353-3658  
Fax: 617-353-9646  
access@bu.edu  
www.bu.edu/disability
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 ODS 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?
      o Medical evaluation
      o Structured or unstructured interviews with student.
      o Interviews with other persons (i.e. parent, teacher, coach).
      o Behavioral observations.
      o Diagnostic Imaging (CT, EEG, MRI, other)
      o Neuropsychological or cognitive testing. Attach documentation.
      o Psychological testing. Attach documentation.
      o Other exam: Specify ________________________________
b. **Current Symptom Checklist.** Please indicate all relevant symptoms and rate current severity:

<table>
<thead>
<tr>
<th>Current Symptom</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Photosensitivity</td>
<td></td>
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<tr>
<td>Cognitive Fatigue</td>
<td></td>
<td></td>
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<tr>
<td>Visual Fatigue</td>
<td></td>
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<tr>
<td>Attention/Concentration</td>
<td></td>
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<tr>
<td>Memory and Learning (encoding and retention of new information)</td>
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<tr>
<td>Memory (recall/retrieval)</td>
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<tr>
<td>Neurobehavioral Symptoms (impulse control/ irritability/mood)</td>
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<tr>
<td>Noise Sensitivity</td>
<td></td>
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<tr>
<td>Physical Symptoms (headache, nausea, dizziness)</td>
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<tr>
<td>Problem Solving</td>
<td></td>
<td></td>
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<tr>
<td>Rate of Information Processing</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Motor or Sensory Symptoms</td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
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</tbody>
</table>


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:

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

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

b. 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.

<table>
<thead>
<tr>
<th>Suggested Accommodations:</th>
<th>Rationale:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance flexibility</td>
<td></td>
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<tr>
<td>Reschedule exams</td>
<td></td>
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<tr>
<td>Extensions for projects or papers</td>
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<tr>
<td>Physical Rest</td>
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<td>-------------------------------</td>
<td></td>
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<tr>
<td>Cognitive rest: please define scope</td>
<td></td>
</tr>
<tr>
<td>Brief Breaks During exams</td>
<td></td>
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<tr>
<td>Part Time Status/taking fewer classes</td>
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<tr>
<td>Lower Lightening During exams</td>
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<tr>
<td>Assistive Technology</td>
<td></td>
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<tr>
<td>Note Taker</td>
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<tr>
<td>Extra time on exams</td>
<td></td>
</tr>
<tr>
<td>Brief Breaks during exams</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
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</tbody>
</table>

**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 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.

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,
25 Buick Street Suite 300
Boston, MA 02215
Phone: 617-353-3658
Fax: 617-353-9646