Access Services for Students with Disabilities
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Hearing Loss Disability Disclosure Form

For Office Use Only

Date Received:

The licensed clinician or health care provider **who is treating this patient for the diagnosis identified** in this document **must** complete this form.

INCOMPLETE FORMS WILL DELAY POTENTIAL SERVICES

Student's Name: _____ Date: _____

Clinician's Name: _____

State Licensure/ Certification #: _____

Area of Specialty: _____ Clinician's phone #: _____

Address: _____

The person named on this form is requesting services from Access Services for Students with Disabilities, which offers services to students who are considered disabled under the mandates of the Americans with Disabilities Act of 1990 (ADA). Under the ADA guidelines a person with a disability is one with a physical, mental, emotional or chronic health impairment that ***substantially limits*** one or more major life activity such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

- **I verify that the person named in this document has a substantially limiting disorder that meets the aforementioned ADA disability criteria: Yes ☐ No ☐**

If yes, please thoroughly complete this form to document the substantial limitations that are linked to this disorder.

1. Diagnosis/Description of the chronic or degenerative disorder or primary disability: **Please provide full ICD code:**

2. Initial Date of Diagnosis:

3. Date of last clinical contact:

4. Expected duration of disability noted above is:

- ☐ Permanent
- ☐ Chronic
- ☐ Long term (3-12 months)
- ☐ Short term (60-90 days)
- ☐ Temporary (1-60 days)

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5. Level of hearing loss is: **Mild** **Moderate** **Severe** **Profound**

6. Assessment Instruments and Results (Please describe the procedures, assessment tools, etc. used to establish the diagnosis)**:**

8. Medications:

Current medications (dosage and side effects):

Long term medication plan:

Current compliance with medical plan:

9. History of hospitalization:

10. Describe the symptoms of this diagnosis that student experiences:

11. Is this student aware of any realistic limitations regarding how the hearing loss may impact their academic performance?

Functional Impact

Please complete this section so that we may better serve this student in the Academic and Residential settings

Describe below how these symptoms substantially limit student's functioning in the academic and residence hall setting:

Please comment on the following items as applicable:

If Deaf-Blind, rate Mobility and Orientation *(travel skills)***:**

□ Novice □ Intermediate □ Advanced

(***Please include current vision evaluation report; see Disclosure Form for Blind/Vision Impairment***)

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Communication method (indicate all that are used):

- ☐ American Sign Language
- ☐ Signed English
- ☐ Other Signed Language (e.g. Spanish)
- ☐ Cued Speech
- ☐ Oral English
- ☐ Oral Other Language: _____
- ☐ Tactile Sign Language
- ☐ Close Vision Signing
- ☐ Other: _____

This person uses any or all of the following (indicate specific device or service):

- ☐ Hearing Aids
  - ___Bilateral
  - ___Unilateral

  (type/model:_____)
- ☐ Cochlear Implant. Type: _____
  Month/Year of surgery: _____
- ☐ Service Animal (Hearing Dog)
- ☐ Assistive Listening Device (please specify:_____)
- ☐ Other Technology/Aids (please specify:_____)

Month/Year of most recent map: _____

Suggested accommodation(s) for the academic setting:

- ☐ Alternate Text Formats (Deaf-Blind)
- ☐ Assistive Listening Device
- ☐ Captioned Media
- ☐ Housing (circle any that apply)
  - o Signaling: Visual and/or Vibration
  - o Service Animal
    - o Relief Area
  - o Other: _____

Additional information:

Clinician Signature:_____Date:_____

Revised 11/2016