Access Services for Students with Disabilities
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Cambridge, MA 02138
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Traumatic Brain Injury 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 traumatic brain injury or primary disability: **Please provide full ICD code:**

2. The extent of the disorder is: ☐ Mild ☐ Moderate ☐ Severe

3. Initial Date of Diagnosis: **4.** Date of last clinical contact:

5. Expected duration of medical disorder or disability noted above is:
- ☐ Permanent/ Chronic
- ☐ Long term: 3-12 months

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6. What is the frequency and duration of symptoms of the student's condition?

☐ Daily ☐ 1/week ☐ 1-3/week ☐ 1/month ☐ 1-3/year ☐ Seasonal

☐ None – symptoms under control with medication ☐ Other:

7. Assessment Instruments and Results: (Please describe the procedures 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. Does this person create a threat to themselves or others (explain)?

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11. Describe the functional impact of symptoms in the academic setting:

12. Is this student aware of any realistic limitations regarding how the traumatic brain injury may impact their academic performance?

13. Suggested accommodations:

14. Additional information:

Clinician Signature: _____Date:_____

Revised 03/2015