Neurological Conditions Documentation Form

Student Name: _______________________________ DOB: ____ / ___ / _____ has requested disability support services from the Office of Disability Services for Students (DSS) at Indiana University Bloomington (IUB) in regard to a neurological condition. Documentation provides vital information about the functional limitation of the student’s disability and its impact in a post-secondary academic environment.

Neurological disorders are numerous and refer to impairment of the nervous system, including the brain, spinal cord, nerves, and muscles. Examples of neurological disorders include, but are not limited to: cerebral palsy, seizure disorders, sleep disorders, Multiple Sclerosis, stroke, or traumatic brain injury.

Please complete all sections of this form and return it as soon as possible so that we may verify the student’s eligibility for services. Providers may also use their own documentation format as long as all of the information requested below is included; if this information is not provided, services may be delayed as DSS obtains clarification. Please call 812-855-7578 if you have questions. The completed form may be faxed to 812-855-7650 or it may be mailed to the address at the bottom of this page. DSS welcomes any additional documentation you would like to include.

Diagnoses:

Primary: 
Secondary: 

Date of Diagnosis: ____ / ____ / _____ Initial visit: ____ / ____ / _____ Last appointment: ____ / ____ / _____

Basis on which diagnosis was made:

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Clinical Manifestations or Current Symptoms:

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Characteristics of Neurological Condition: (Check all Appropriate Terms)
☐ Stable  ☐ Slow Progressing  ☐ Rapid Progressing  ☐ Improving  ☐ Mild  ☐ Moderate  ☐ Severe

Current medical treatment that may affect the student in the higher education environment.

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Do the student’s symptoms fluctuate or worsen ☐ Yes  ☐ No  If yes, please explain:

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
How long do you anticipate the condition impacting academic achievement? (Check one)
☐ < 6 months   ☐ < 1 year   ☐ > 1 year

Prescribed medication and the side effects that impact academic functioning:
___________________________________________________________________________________________
___________________________________________________________________________________________

Implications for Educational Success/Major Life Activities (REQUIRED):
Please check which of the major life activities listed below are affected because of the diagnosis.
*Note: Appropriate psychometric data should be included for these areas of limitation.

☐ Concentration*       ☐ Cognitive functioning*       ☐ Communication
☐ Memory*              ☐ Processing speed*            ☐ Motor Skills
☐ Sleeping             ☐ Walking                          ☐ Lifting
☐ Other ______________  ☐ Other ______________          ☐ Other ______________

Additional comments and recommended auxiliary support, strategies, or service that may be beneficial to the student in the higher education environment.
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Certifying Professional
Name (print): ____________________________________________ Date: _____ / ____ / _____
Profession: ____________________________ License number: ____________________________
Office Address: _____________________________________________________________________________
Phone: __________________ Fax: __________________________ Email Address: _____________________
Certifying Professional Signature: _____________________________________________________________