

TO:

FROM:

Webster University

RE: Criteria For Documenting Head Injury/Acquired Brain Injury

The following student, _____ (DOB _____), has applied for support services available to qualified individuals with disabilities through Webster University. Current and comprehensive documentation of the student's disability must be on file at Webster University in order to determine appropriate and reasonable accommodations. The student has indicated that you could provide documentation of disability, along with information pertinent to functioning in college. Please address the criteria outlined below on professional letterhead or complete the attached verification form. A signed release of information form is enclosed.

CRITERIA FOR DOCUMENTING HEAD INJURY/ACQUIRED BRAIN INJURY

1. A current statement of the head injury or acquired brain injury, including probable site(s) of lesion(s).
2. A summary of assessment procedures and evaluation instruments used to make the diagnosis.
3. A narrative summary of cognitive and achievement measures and evaluation results, including standardized scores, used to make the diagnosis.
4. A summary of present residual symptoms which meet the criteria for diagnosis.
5. Medical information to be considered in a college environment, including medication needs.
6. Suggestions of reasonable accommodations (should be supported by the diagnosis).
7. A description of personal care concerns.

WEBSTER UNIVERSITY DISABILITY VERIFICATION FORM
STUDENTS WITH HEAD INJURY/ACQUIRED BRAIN INJURY

STUDENT NAME: _____

DATE: _____

SOCIAL SECURITY NUMBER: _____

I.D. #: _____

DIAGNOSTIC INFORMATION

ICD/DSM-IV diagnosis: _____

Statement of Head Injury/Acquired Brain Injury, including probable site(s) of lesions: _____

Pertinent History: _____

Assessment procedures and evaluation instruments used: _____

Attach diagnostic report, including a narrative summary of cognitive achievement measures used and evaluation results, including standardized scores. Describe present residual symptoms: _____

Prognosis: _____

MEDICATION/TREATMENT INFORMATION

Describe current medication needs and side effects and how the medication may affect the student's educational performance: _____

How long has the student been taking this medication? _____

Is the student still adjusting to or stabilized on the medication? _____

Does the student need to take medication during class hours? _____ If yes, please explain? _____

INFORMATION SUPPORTING ACCOMODATION REQUESTS

Describe the student's functional limitations in an educational setting: _____

Please describe any mobility issues/concerns associated with the student's disability: _____

Will the disability affect the student's class attendance? If yes, please explain. _____

How will the disability affect the student's class participation (attending lectures, doing research, writing papers, reading large amounts of information, meeting deadlines, working in small and large groups, etc.)? _____

Describe cognitive deficits manifested in memory impairment, cognitive disturbances (aphasia, apraxia, agnosia), and/or disturbances in executive function (planning, organizing, sequencing, abstracting). _____

Have you any recommendations to make regarding effective academic accommodations to equalize this student's educational opportunities at the post-secondary level? (Describe services/accommodations for exam administration, classroom or study activities, or course requirements). _____

OTHER INFORMATION

Assistive devices: _____

If the student has accompanying seizure activity, please describe the following:

Type of seizure activity: _____

Severity: _____

Frequency and length of typical seizure activity: _____

Emergency procedures which should be followed: _____

CERTIFYING AUTHORITY

SIGNATURE: _____

PRINT NAME AND TITLE: _____

ADDRESS: _____

PHONE: _____ **FAX:** _____ **DATE:** _____

**Please accompany this form with a note on your professional letterhead describing
how long and under what conditions you have treated this patient.**