To be completed by a healthcare professional

University of Wisconsin Whitewater | Center for Students with Disabilities

Disability Assessment Form

To Whom It May Concern:

A patient/client of yours has requested disability-related services from the Center for Students with Disabilities (CSD), University of Wisconsin-Whitewater. Legal protection and eligibility for such services is based on a student providing sufficient information to conclude that he or she has an impairment that **substantially limits** one or more major life activities. As this student's treating specialist, you are asked to provide the following information to allow the university to consider this student's service request(s).

Please complete the following:

1. Patient/Client Name:

2. The Condition of Patient/Client:

A. What is the diagnosis/impairment? _____

B. Date of diagnosis: _____

C. Date of first contact with the student: _____

D. Date of last contact with student: _____

E. Is the student currently under your care? _____

F. Is the impairment temporary (< 3months) or persistent? _____

G. Current medications: _____

H. Please identify any factors that may affect the severity of the impairment (e.g., to what degree might the impairment be *minimized* by medications, hearing aids, etc.?) Alternatively, could there be an adverse affect (e.g., medication side effects)?

_____

_____

3. Please complete the following: FUNCTIONAL IMPACT ASSESSMENT

LIMITATION IS: 1 =Unable to Determine 2 = Mild 3 = Substantial

1	2	3	Major Life Activity		1	2	3	Major Life Activity
			Caring for oneself					Learning
			Talking					• Reading
			Hearing					• Writing
			Breathing					• Spelling
			Seeing					• Calculating
			Walking/Standing					• Concentrating
			Lifting/Carrying					• Memorizing
			Sitting					• Listening
			Performing Manual Tasks					Other:
			Eating					
			Working					
			Interacting with Others					
			Sleeping					

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Please complete reverse side

4. What method(s) were utilized to assess functional limitation? Please list or attach under separate cover.

- ☐ Behavioral observations
- ☐ Developmental history
- ☐ Rating scales
- ☐ Medical history
- ☐ Structured or unstructured clinical interviews with the student
- ☐ Neuropsychological or psychoeducational testing
  - o Dates of testing _____
- ☐ Other (please specify) _____

_____

(Please attach/fax diagnostic report of assessment)

5. List current symptoms/problems, functional limitations. Describe the differential diagnoses that were ruled out.

_____

_____

_____

6. Please list your recommendations for accommodations within the academic environment. Please provide a rationale for any recommendation made utilizing data from objective measures, the educational record, or other data sources. Please list or attach under separate cover.

_____

_____

_____

_____

7. Certifier Information:

Clinician Name_____

Medical Specialty_____ License #_____

License_____

Address_____

Phone_____Email_____Date_____

☐ Check if completed by someone other than the treatment provider.

Please send this completed form and any additional information to:

Center for Students with Disabilities
Mail: 800 W. Main St.
2002 Andersen Library
Whitewater, WI 53190

Fax: (262) 472-4865
Email: csdat@uww.edu
Phone: 262-472-4711 (voice, TTY, relay)

If you have questions, please feel free to contact our office.
Thank you!