UNIVERSITY OF WEST GEORGIA

Acquired Brain Injury Documentation Instructions and Form

Updated March 2024

Student Instructions and Information:

- Students must submit **current** documentation to the Office of Accessibility and Testing Services. Impairments following an acquired brain injury may change rapidly in the weeks and months after the injury. A stable picture of residual weaknesses may not be apparent for 1-2 years after an injury. Documentation should reflect data collected within a month at the time of request for services. Less recent documentation may be submitted for review, but may not be accepted if it fails to adequately indicate current functioning.
- A qualified provider (medical doctor, psychologist or psychiatrist) must provide the documentation.
- In place of this form, a letter may be provided including all of the requested information. Any letters must be on letterhead from the provider's practice. Any documentation must include the provider's signature and credentials.
- Students are encourage to provide documentation **prior to the intake meeting** if at all possible. It is during the intake meeting that appropriate accommodations, and the process for using the accommodations, will be discussed. **Based on the student's individual situation, it will be determined when updated documentation will be required in order to continue providing the most appropriate accommodations.**
- For timely review of application, documentation must be submitted by the student requesting services via our secure portal, AIM located on our website. If you have any questions regarding this process, please email to accessibility-services@westga.edu.

To be Completed by Student:

Name (Last, First, Middle):_____

Date of Birth: _____ UWG ID Number: 917_____

Cell Phone: _____ Alternate Phone: _____

Home Address: _____

_____

Email Address: _____

Status (Check One): ____Current Student ____ Transfer Student ____ Prospective Student

To be Completed by Provider:

The Office of Accessibility and Testing Services establishes academic and/or housing accommodations for students with a documented disability. The Americans with Disabilities Act (ADA) defines a disability as a physical or mental impairment that substantially limits one or more major life activities. The University System of Georgia Board of Regents (USGBOR) requires current and comprehensive documentation for any diagnosis of a disability in order for disability services providers to determine appropriate accommodations and services. Please see Appendices D-H of the USGBOR Academic and Student Affairs Handbook for more information.

Please provide the date or period of time of the brain injury, as well as the nature of the neurological illness or traumatic event that resulted in the brain injury.

_____

_____

_____

If a DSM-5 diagnosis is appropriate, please complete the following:

Primary Diagnosis:_____

DSM-5 Code:_____Date of Diagnosis:_____

Secondary Diagnosis:_____

DSM-5 Code:_____Date of Diagnosis:_____

Please provide the diagnostic criteria and methodology used to diagnose the condition.

_____

_____

_____

Is it expected that the patient's functioning and/or severity of the impact of the injury will change over time?

_____Yes _____No

If yes, please explain the anticipated progression.

_____

_____

_____

Please explain the current functional limitations. **The functional impact of the brain injury must be documented by appropriate, objective measures (e.g. cognitive and academic skills, psychosocial-emotional functioning, and/or sensory abilities) relevant to the academic environment. Attach additional documentation to fully document the limitations as appropriate.**

_____

_____

_____

_____

_____

Please provide any recommendations to address the indicated functional limitations.

_____

_____

_____

_____

Please attach any psychological and/or educational reports that support the functional impact of the brain injury and complete the following information:

Provider Name:_____

Title:_____

License #:_____

Practice Name and Address:_____

_____

Phone:_____Fax:_____

Email:_____

Provider Signature **(REQUIRED)**:_____

Date of Signature:_____