



**ACCESSIBLE EDUCATION DOCUMENTATION QUESTIONNAIRE
PHYSICAL DISABILITY - CHRONIC HEALTH - BRAIN INJURY**

Name of client: _____ Birthdate of Client: _____

Attending Provider: _____

Provider Title: _____

Professional credentials, licensure, and/or specialization credentials:

Office Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

If you have questions or need assistance please contact Accessible Education Services via email aes@up.edu or phone at 503-943-8985.

GUIDELINES:

This questionnaire is designed to provide Accessible Education Services with information to assist with the interactive accommodation process. The student's psychiatrist, psychologist, licensed social worker, relevantly trained M.D., or mental health nurse practitioner must complete and sign the questionnaire. The provider may, as an alternative, write a letter or report that contains the same information. The University will only accept documentation from a practitioner who demonstrates a legitimate and on-going health care provider/patient relationship. All questions should be answered thoroughly. Accessible Education Services may ask for additional information if documentation is incomplete or does not support the accommodations requested. It is not acceptable for documentation to include a diagnosis or testing battery performed by a member of the student's family. It is the general policy of the University Health and Counseling Center (HCC) that the HCC does not provide documentation for AES accommodation requests.

INTERACTIVE ACCOMMODATION PROCESS:

The legal definition of disability includes two elements: (1) a physical or mental impairment which (2) substantially limits one or more of the major life activities of the person in question. Major life activities include but are not limited to: walking, breathing, seeing, hearing, performing manual tasks, caring for one's self, learning, bodily systems such as immune function, and working. Thus, disability has both diagnostic and functional elements, and **BOTH elements need to be documented for effective accommodation determination.**

I. DIAGNOSIS

Diagnostic code(s) (ICD-10 or DSM-V): _____ Diagnosis Name: _____

Date of diagnosis: _____

Date of first in-person visit: _____ Date of last in-person visit: _____ Total number of visits: _____

Severity level (indicate for each diagnosis if more than one):

Please summarize relevant history, clinical observations, and/or physical exam findings that demonstrate how student is substantially limited by this diagnosis:

II. TREATMENT

What treatments medications, and/or assistive devices have been recommended or prescribed?

III. FUNCTIONAL LIMITATIONS

What accommodations do you suggest for the academic setting? Please supply a rationale for each, based on the student's present level of functioning.

Recommended Accommodations	Rationale

Please supply any other information that should be considered in determining appropriate and effective accommodations for this student.

Signature: _____

Date: _____

Name and title (printed) : _____

Please return this form to the student. They will need to attach this documentation to their accommodation request.

Thank you for your assistance.