Disability Services
disabilityservices@byuh.edu
808-675-3518

VERIFICATION FORM for NEUROLOGICAL DISORDERS

BYU–Hawaii supports a climate of equal opportunity in its programs, activities, and services according to applicable law, including providing accommodations for students with disabilities. As part of the process for requesting accommodations, a student must provide documentation from a qualified practitioner who is the primary treating professional (e.g., licensed physician, neurologist, clinical psychologist, or neuropsychologist) regarding the student's neurological disorder, associated symptoms, related medications, and their impact on the student's major life activity, and their need for accommodations. This Verification Form may supplement information that is provided in other reports, including neurological reports, neuropsychological evaluations, or secondary school documentation. Any documentation, including this Verification Form, must meet BYUH DS guidelines for neurological disorders.

A summary of the guideline criteria for documenting neurological disorders is listed below (more information related to DS documentation and guidelines for neurological disorders can be found at the following website: https://disability.byuh.edu/.

1. Evidence of current neurological impairment
2. Functional impairment affecting an important life skill, including academic functioning
3. Symptoms and functional impairment attributed to neurological disorder determined through the administration of a neurological diagnostic test and/or a neuropsychological evaluation
4. Exclusion of alternative diagnoses
5. History relevant to current neurological impairment
6. Summary and recommendations

This form will be reviewed by the Disability Services Coordinator (DSC) who will verify the disability as to the reliability of the request. The DSC will then notify the student if they are eligible for accommodations.

I. Student Information Section: (Please Print Legibly or Type)

BYUH ID #: ____________

Student's Name

First: ____________

Middle: ____________

Sur/Last: ____________

Date of Birth: ____________

Student's Current Address:

Street: ____________

City: ____________ State: ________ Zip: ____________

Phone: ____________

Email: ____________

II. Provider Section:

1. Contact with Student

a. Date of initial contact with student:

b. Date of last contact with student:

c. Frequency of appointments with student (e.g., once a week, once a month):

2. Diagnosis

a. What is the student's diagnosis?

b. How long has the student had this disorder?

c. What is the severity of the disorder? Mild ☐ Moderate ☐ Severe ☐

i. Explain the severity checked above:

d. What is the expected duration of the disorder? Chronic ☐ Episodic ☐ Short-term ☐

i. Explain the duration checked above:

e. Current Symptoms:

i. Please provide information regarding the student's current presenting symptoms:

Use the back, if necessary

ii. Is there clear evidence that the symptoms associated with the neurological disorder are interfering with or reducing the quality of at least one of the following, including academic functioning? Describe how the impairment interferes with functioning.

School functioning:	
Social functioning:	
Work functioning:	

iii. Did you use a neurological diagnostic test and/or neuropsychological evaluation to obtain information about the student's symptoms and functioning in various settings?

Yes ☐ No ☐

iv. If yes, on what date(s) was the neurological diagnostic test and/or neuropsychological evaluation completed? *Please include a copy of the test/evaluation with the submission of this Verification Form*.

v. If no, how did you reach your conclusion about the neurological disorder diagnosis, symptoms, and treatment?

Use the back, if necessary

f. ***DSM-5* Codes**:

i. Please include all pertinent diagnoses or rule-out diagnoses using *DSM-5* codes.

Principal Diagnosis: ____

Code: ___________________________

Severity or Level of Impairment: _____________________________________

Descriptive Features: ____

Course:____

Other Diagnoses: ____

Code:____

Severity or Level of Impairment: _____________________________________

Descriptive Features: ____

Course:____

WHODAS 2 Score (If given): _________________

3. Student's History

a. Please include any historical information relevant to the student's neurological disorder and associated functioning (e.g., developmental, familial, medical, pharmacological, psychological, psychosocial).

4. Medications

a. Is the student currently taking medication(s) for symptoms associated with the neurological disorder?

Yes ☐ No ☐

b. If yes, please provide information below for each medication the student is currently prescribed:

Use the back, if necessary

Medication/Dosage/Frequency:	
Date Prescribed:	
Side effects that impact the student’s functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication/Dosage/Frequency:	
Date Prescribed:	
Side effects that impact the student’s functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication/Dosage/Frequency:	
Date Prescribed:	
Side effects that impact the student’s functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication/Dosage/Frequency:	
Date Prescribed:	
Side effects that impact the student’s functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Use the back, if necessary

5. Functional Limitations and Recommended Accommodations

a. Please list the student's current symptoms associated with the neurological disorder and indicate what reasonable academic accommodations would mitigate the symptom listed. More detailed information regarding reasonable academic accommodations can be found on the DS website at: https://disability.byuh.edu/

Symptom:
Recommended Reasonable Accommodation(s):

Symptom:
Recommended Reasonable Accommodation(s):

Symptom:
Recommended Reasonable Accommodation(s):

*Use the back, if necessary.

III. Provider's Certifying Professional Information:

Professionals conducting the assessment, rendering a diagnosis, and providing recommendations for reasonable accommodations must be qualified to do so (e.g., licensed physician, psychiatrist, clinical psychologist, or neuropsychologist). The provider signing this form must be the same person answering the above questions.

***Note**: For ethical reasons, documentation from a family member or relative cannot be accepted, even if they are licensed.

Provider's Name: (International Providers, please fill out as much information as possible about your qualifications)

First:

Middle:

Last:

Credentials:

License Number*:

State of Licensure:

Street Address:

City:

State:

Zip:

Phone #:

Email Address:

Stamp Here (unless provider is from BYUH):

Signature of Provider: Date:

** ***I authorize BYU–Hawaii to receive information from the healthcare provider above. I also authorize my healthcare provider to discuss relevant information as to my condition(s) with the appropriate and qualified BYU–Hawaii personnel on an as-needed basis.***

Signature of Student: Date:

Submitting this Form:

This form may be returned to the student or submitted directly to the Disability Services Office at BYU–Hawaii. Information regarding BYU–Hawaii's Disability Services Office can be found at: https://disability.byuh.edu/. If you have any additional questions, you may contact disabilityservices@byuh.edu or 808-675-3518. Thank you for assisting BYU–Hawaii in this accommodation process.