DePaul University
DIVISION OF STUDENT AFFAIRS
Center for Students with Disabilities

Professional Provider Documentation Guidelines

Thank you for providing disability documentation for this student. Students requesting enrollment with the Center for Students with Disabilities (CSD) are required to submit documentation regarding their disability(s) from an appropriate licensed professional provider to register with the CSD. Submitted documentation does not determine accommodations but is an important component of the student's enrollment process.

In accordance with regulations contained within the Family Educational Rights and Privacy Act (FERPA) and DePaul University's Compliance policy, the DePaul University Center for Students with Disabilities (CSD) will disclose to designated parties information from the education records of a student provided the CSD has on file written consent by the student.

Important Note: If you will require the student to complete an additional release form to release documents or information, please make sure that the consent for disclosure is broadly worded to allow for release to "DePaul University'' for the purpose of "participation in educational programs at the university." Please include a copy of this signed release form with any documentation provided.

There are several documentation submission options including: submission of a written statement; photocopies of relevant medical records; and/or completion of the CSD Disability Information and Verification Documentation form. All documentation must be current and relevant. Appropriate documentation will vary depending on the nature of a student's disability(s). Submitted documents are not determinative of accommodations. If needed the CSD may request additional documentation and/or clarification.

A written statement may include (but is not limited to):

1. **A diagnostic statement identifying the disability:** Include ICD or DSM diagnostic codes, the date of the most recent evaluation, or the dates of evaluations performed by referring professionals.
2. **The expected progression or stability of the described diagnosis over time:** Provide an estimate of the impact of the disability over time. Include the predicted need for future reevaluation.
3. **Current functional impact of the disability:** Describe the current functional impact on physical (including mobility, dexterity, and endurance), perceptual, cognitive (including attention, distractibility and communication), and behavioral abilities. Include severity, information on variability over time and potential environmental or circumstantial triggers.
4. **Treatments, medications, accommodations, assistive devices currently prescribed or in use:** Describe treatments, medications, assistive devices, and/or accommodations currently used. Include the estimated effectiveness in ameliorating the impact of the disability. Include any significant side effects that may impact physical, perceptual, behavioral or cognitive performance.
5. **Emergency Protocols:** Provide succinct emergency directives if the student is known to have life-threatening allergies or neurological anomalies. Specify all allergens and environmental triggers.
6. **Additional information:** Provide any additional relevant documentation.

Completion of the CSD Disability Information and Verification Form:

The CSD also provides the option of completing the **CSD Disability Information & Verification Documentation** form. The student will provide you with this form upon your request.

1. Please complete the entire form. Typing is preferred. An electronic version of the form is available at http://go.depaul.edu/csd. Inadequate information, incomplete answers or illegible handwriting will delay the review process.
2. If the student has multiple diagnoses, please complete the form addressing each diagnosis.
3. Attach any relevant supporting documentation

Please submit completed form by email: csd@depaul.edu or fax: 773.325.3720 (Lincoln Park) or 312.362.6544 (Loop)

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CSD Disability Information and Verification Form

<u>Student Information (to be completed by student)</u>

By signing below, I request that the licensed professional named below complete the attached diagnostic information.

Student Signature: ____ Date: ________________

Date of Birth: ______________________ Student ID #: _____________________________________

Status (check one): Current Student ________ Transfer Student _______ Newly Admitted Student ________

Phone Number: __________________________ Email: ___________________________________

Name of Licensed Professional: _________________________________ Title: ___________________

<u>Licensed Professional Information (to be completed by professional)</u>

By signing below, I agree that the attached information is accurate to the best of my knowledge and provided in accordance with my best professional judgment.

Provider Signature: ____ Date: ___________________

Provider Name: ____

Title: ___________________________ License #: _____________________ State: ______________

Address: ____

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Phone Number: _________________________ Email: ______________________________________

Diagnostic Information (to be completed by licensed professional)

1. Student Name: ____

2. Date of first contact with student: _______________ Date of last contact with student: _________________

3. What is the ICD and/or DSM-V diagnosis(s) for this student? Please include date of diagnosis and diagnostician.

ICD or DSM V	Diagnosis	Date of Diagnosis	Diagnostician

4. Describe the symptoms that meet the criteria for the above diagnosis(s):

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5. What tests, assessments or evaluations were used to determine the above diagnosis(s)? Please attach test results and diagnostic reports:

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6. Please list all medications and therapies, including OTC and non-medication treatment (including therapy, if applicable), which the student is current using to manage this condition.

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7. Do current medications and/or treatments mitigate the functional impact of the condition? If no, please explain.

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8. How frequently is the student affected by this condition?

   Daily   Weekly   Monthly   Seasonally   Other: ________________________________

9. Describe the expected duration and/or progression of the diagnosis(s):

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10. Please describe any situations or environmental conditions that may might exacerbate the student's disability or symptoms:

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11. Are there accommodations, services, or auxiliary supports that are recommended for this student? Please explain:

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12. If a **housing accommodation** is recommended, describe the current impact of the diagnosis(s), including the negative health impact that may result if housing recommendation are not met. Please be specific as the student's diagnosis(s) must be directly related to their inability to live in a traditional residential community:

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13. If an **Assistance/Emotional Support Animal** is recommended, describe the current impact of the diagnosis(s), including the negative health impact that may result if Assistance/Emotional Support Animal is not granted. Please be specific as the student's diagnosis(s) must be directly related to their inability to live without an Assistance/Emotional Support Animal:

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14. Please indicate impact of the student's disabilities on the following major life activities:

Life Activity	Negligible	Moderate	Substantial	Severe	Don't Know
Seeing					
Hearing					
Speaking					
Sitting					
Standing					
Walking					
Breathing					
Eating					
Sleeping					
Lifting					
Preforming fine motor tasks					
Preforming self-care tasks					
Learning					
Thinking					
Concentrating					
Managing external distractions					
Managing internal distractions					
Initiating tasks					
Short term memorization					
Long term memorization					
Stress management					
Anxiety management					
Anger management					
Following through on responsibilities					
Integrating sensory information					
Integrating visual information					
Following directions					
Communicating needs					
Social interaction					
Writing mechanic					
Composition					
Reading speed					
Reading comprehension					

15. Please describe the actual functional limitation of this condition.

16. Does this student have any life-threatening allergies? Yes No

Allergy	Symptoms	Protocol

17. Does this student have **any** emergency medical plan? Yes No

A medical plan is attached Yes No

18. Additional information: