DEPAUL UNIVERSITY

DIVISION OF STUDENT AFFAIRS

Center for Students with Disabilities

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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 in order 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 in order 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 & Verification Documentation 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 editable PDF version is available on our website www.studentaffairs.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 documentation to either campus

Center for Students with Disabilities
DePaul University – Lincoln Park Campus
2250 North Sheffield Ave.
Student Center - Suite 370
Chicago, IL 60614
773.325.1677 *phone*
773.325.3720 *fax*
csd@depaul.edu

Center for Students with Disabilities
DePaul University – Loop Campus
25 East Jackson Blvd.
Lewis Center – Suite 1420
Chicago, IL 60604
312.362.8002 *phone*
312.362.6544 *fax*
csd@depaul.edu

Thank you

5/15/18

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CSD Disability Information & Verification Documentation Form

STUDENT INFORMATION (to be completed by the student)
(Please type or print clearly)

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

Student Signature: ____ Date: __________

Student Name: ____

Date of Birth: ____________________ Student ID #___________________________________

Status (check one): ☐ Current Student ☐ Transfer Student ☐ Newly Admitted Student

Contact Telephone Number: __________________ Contact Email: ___________________________

Name of Licensed Professional: ___________________________________ Title: _________________

LICENSED PROFESSIONAL INFORMATION (to be completed by professional)
(Please type or print clearly)

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: ____

____

Telephone Number: ________________________ FAX Number: ____________________

Email: ____

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

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

6. Describe the treatment <u>history</u> (e.g. pharmacological, medical, counseling).

7. Describe <u>current</u> treatments (e.g. pharmacological, medical devices, adaptations, counseling).

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

DIAGNOSTIC INFORMATION (cont.)

(To be completed by licensed professional)

9. Please indicate impact of the student's disability(s) 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					
Performing fine motor tasks					
Performing self-care tasks					
Learning					
Thinking					
Concentrating					
Managing external distractions					
Managing internal distractions					
Initiating tasks					
Short term memorization					
Long term memorization					
Stress management					
Anger Management					
Anxiety Management					
Following through on responsibilities					
Integrating sensory information					
Integrating visual information					
Following directions					
Communicating needs					
Social Interaction					
Writing mechanic					
Composition					
Reading speed					
Reading comprehension					

RECOMMENDATIONS

(To be completed by licensed professional)

10. Are there any other limitations that should be considered for this university student?

___

___

___

11. Are there auxiliary aids or services that are recommended for this student? Please explain.

___

___

___

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

___

___

___

13. Does this student have any life threatening allergies? ☐ Yes ☐ No

Allergy	Symptoms	Protocol
Allergy	Symptoms	Protocol
Allergy	Symptoms	Protocol

14. Does this student have **any** emergency medical plan? ☐ Yes ☐ No
A Medical Emergency Plan is attached. ☐ Yes ☐ No

15. Additional information: ___

___

___

Thank you

5/15/18