Verification Form

Mobility & Upper Extremity Disorders

Bucks County Community College | Accessibility

Bucks County Community College's Accessibility Office (TAO) has established the Verification Form for Mobility & Upper Extremity Impairments to obtain current information from a licensed medical practitioner regarding a student's mobility or upper extremity impairment and its impact on the student and his or her need for accommodations. This Verification Form may supplement information that is provided in other reports, including medical reports, physiological assessments, or secondary school documentation. Any documentation, including this Verification Form, must meet Bucks County Community College's TAO guidelines for Mobility & Upper Extremity Impairments.

The person completing this form may not be a relative of the student or hold power of attorney over the student.

A summary of the guideline criteria for documenting Mobility & Upper Extremity Impairments is as follows:

1. Evidence of current mobility or upper extremity impairment
2. Functional impairment affecting an important life skill, including academic functioning
3. History relevant to current Mobility or Upper Extremity Impairment(s), including use of assistive or adaptive technology
4. Summary and recommendations

Section I: Student Information (Please type information or print legibly)

Student Name: _____
Last First Middle

Student ID: _____ **Date of Birth:** _____

Cell Phone: _____ **Home Phone:** _____

Bucks Email: _____ **Home Email:** _____

Permanent Street Address: _____

_____

City: _____ **State:** _____ **Zip:** _____

(If different from Permanent Street Address)

Local Street Address: _____

_____

City: _____ **State:** _____ **Zip:** _____

Section II: Provider Section (Please type information or print legibly)

A. Contact with the Student:

Date of initial contact with the student: _____

Date of last contact with the student: _____

B. Diagnosis Information:

1. Clinical History

Does the student have a clinical history (i.e., prior to age 12) of mobility or upper extremity impairment symptoms? ☐ **YES** ☐ **NO**

Approximately at what age did the student start to exhibit mobility or upper extremity impairment symptoms? _____

What date was the student diagnosed with mobility or upper extremity impairment symptoms? _____ Month _____ Year

2. Diagnosis, Condition and Symptoms

a. Please provide all ICD 10 Codes and diagnoses that apply to the student's current diagnosis:

ICD 10 Code	Diagnosis

b. What is the severity of the impairment? ☐ **Mild** ☐ **Moderate** ☐ **Severe**

1) Please explain the severity checked above:

c. What is the expected duration of the impairment?

Short-term (<6 months):	☐	Long-term (>6 months-1 year):	☐
Episodic:	☐	Chronic (>1 year with frequent recurrence):	☐

1) Please explain the duration checked above:

d. Current Symptoms

1) What is the student's current mobility or upper extremity impairment(s)?

2) What is the date of the student's most current mobility or upper extremity impairment(s) assessment? _____ Month _____ Year

Please attach a copy of the most recent assessment or assessment summary.

e. Is the mobility or upper extremity impairment expected to remain stable or is it expected to decline? ☐ **Stable** ☐ **Decline**

1) Is it expected to decline, please describe the expected progression of the mobility or upper extremity impairment?

f. Ambulation:

1) Is the student able to ambulate? ☐ **YES** ☐ **NO**

a) If yes, how far can the student ambulate without stopping or resting (e.g., one block, one mile, etc.)?

b) If no, how does the student negotiate their mobility restrictions? Does the student use a manual wheelchair, motorized wheelchair, scooter, crutches, etc.? If so, please explain.

c) Can the student negotiate stairs or is an elevator required?

g. Is there clear evidence that the symptoms associated with the mobility or upper extremity impairment are interfering with or reducing the quality of at least one of the following, including academic functioning?

School functioning:	
Social functioning:	
Work functioning:	
Language functioning:	

3. Student History

a. Please include any historical information relevant to the student's mobility or upper extremity impairment and associated functioning (e.g., developmental, familial, medical, pharmacological, psychological, psychosocial).

b. Does the student have a clinical history of alcohol abuse? ☐ **YES** ☐ **NO**

1) Please provide information regarding the student's history of alcohol abuse.

c. Does the student have a clinical history of drug abuse? ☐ **YES** ☐ **NO**

1) Please provide information regarding the student's history of drug abuse.

d. Assistive Technology

1) Does the student currently use assistive or adaptive technology to facilitate mobility? ☐ **YES** ☐ **NO**

a) If yes, please list specifics related to the brand and model number of the assistive or adaptive technology used by the student.

2) Does the student currently own this adaptive or assistive technology? ☐ **YES** ☐ **NO**

a) If yes, what is the brand and model number?

b) State specific recommendations regarding assistive or adaptive technology for this student based upon the student's functional limitations (e.g., if a screen reader is suggested, please relate the request to the student's mobility impairment.) Please be as specific as possible (e.g., brand name, model number.)

4. World Health Organization Disability Assessment Schedule 2.0

a. Does the student have a WHODAS 2 Score? ☐ **YES** ☐ **NO**

b. If yes, please provide the score here: _____

5. Other Diagnosis and ICD 10 Codes?

a. Does the student have any other diagnosis? ☐ **YES** ☐ **NO**

b. If yes, please list the ICD 10 Codes and the diagnoses is the space provided below:

ICD 10 Code:	Diagnosis

6. Military Service

a. Has the student served in the military? ☐ **YES** ☐ **NO**

1) What branch of the military did the student serve with?

☐	United States Air Force	☐	United States Coast Guard	☐	United States Navy
☐	United States Army	☐	United States Marine Corp.	☐	

b. Is the diagnosis related to their service in the military? ☐ **YES** ☐ **NO**

1) Please provide information regarding the student's history of mobility needs related to their military service.

c. Is the receiving treatment through United States Department of Veterans Affairs? ☐ **YES** ☐ **NO**

1) At what location of the VA does the student receive services? _____

C. Family History:

1. Does the student have a family history of physical health impairments? ☐ **YES** ☐ **NO**

2. If yes, please check all that apply:

☐	**Mother**	☐	**Father**	☐	**Siblings**
☐	**Grandparents (Maternal)**	☐	**Grandparents (Paternal)**	☐	**Aunts (Maternal)**
☐	**Uncles (Maternal)**	☐	**Aunts (Paternal)**	☐	**Uncles (Paternal)**
☐	**Cousins (Maternal)**	☐	**Cousins (Paternal)**	☐	

a. If yes, please list the family history of any health disorders.

3. Does the student have a family history of any psychological disorders? ☐ **YES** ☐ **NO**

4. If yes, please check all that apply:

☐	**Mother**	☐	**Father**	☐	**Siblings**
☐	**Grandparents (Maternal)**	☐	**Grandparents (Paternal)**	☐	**Aunts (Maternal)**
☐	**Uncles (Maternal)**	☐	**Aunts (Paternal)**	☐	**Uncles (Paternal)**
☐	**Cousins (Maternal)**	☐	**Cousins (Paternal)**	☐	

a. If yes, please list the family history of any psychological disorders.

5. Does the student have a family history of any physical health disorders? ☐ **YES** ☐ **NO**

6. If yes, please check all that apply:

☐	**Mother**	☐	**Father**	☐	**Siblings**
☐	**Grandparents (Maternal)**	☐	**Grandparents (Paternal)**	☐	**Aunts (Maternal)**
☐	**Uncles (Maternal)**	☐	**Aunts (Paternal)**	☐	**Uncles (Paternal)**
☐	**Cousins (Maternal)**	☐	**Cousins (Paternal)**	☐	

a. If yes, please list the family history of any health disorders.

D. Medication(s):

1. Is the student currently taking medication(s) for any symptoms related to the diagnosis? ☐ YES ☐ NO
2. Does the student have a history of noncompliance with medication? ☐ YES ☐ NO
   a. If yes, please list the behaviors or incidents of noncompliance with medication in the student's history.

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

Medication • Dosage • Frequency (e.g., Tramadol 100 mg 1 x daily):	
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.):	

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.):	

E. Functional Limitations and Recommended Accommodations:

1. Please list any recommended reasonable accommodations that would mitigate the student's current symptoms associated with the mobility or upper extremity impairment beyond the mobility devices and adaptive or assistive technology listed above.

2. **Sample:**

Symptom: (Example)
A student is unable to grip a pen or pencil requiring use of a computer during class or exams.
Recommended Reasonable Accommodation(s):
Student will need assistance with notetaking. Student would benefit from the use of a LiveScribe pen, audio recording lectures or from receiving instructor notes.

Symptom:
Recommended Reasonable Accommodation(s):

Symptom:
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Symptom:
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Symptom:
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Symptom:
Recommended Reasonable Accommodation(s):

Symptom:
Recommended Reasonable Accommodation(s):

Section III: Provider's Certifying Professional Information

(Please type information or print legibly)

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

Provider Name: _____
Last First Middle

Credentials: _____

License Number: _____ **State of Licenser:** _____

Office Phone: _____ **Office Fax:** _____

Office Email: _____ **Office Website:** _____

Office Street Address: _____

_____

City: _____ **State:** _____ **Zip:** _____

Provider Signature: _____ **Date:** _____

Section IV: Submitting This Form

It is the responsibility of the student to submit the form to the Accessibility Office (TAO) at Bucks County Community College where the student is enrolled. The student will submit the form to the Learning Specialist during their intake appointment when they register with TAO. Students will also be required to meet with a Learning Specialist if they would like to update their accommodations using the verification form or any other form of documentation.

Section V: How to Make an Intake Appointment

Students are encouraged to call or email the Accessibility Office (TAO) to schedule an appointment. Intake appointments are only done in person. There are certain times of year that appointment waiting times can be up to six weeks. The student identification number and Bucks email is required for students to obtain an intake appointment. Students are encouraged to contact TAO as soon as possible to ensure that their accommodations are approved and put into place as soon as possible. TAO's contact information is as follows:

Phone: (215) 968-8182

Email: accessibility@bucks.edu

Office: Bucks County Community College
275 Swamp Road
Rollins Center • Student Services Office • Room 001
Newtown, Pennsylvania 18940

Appointments can be scheduled for the Upper Bucks (Perkasie) and Lower Bucks (Bristol) campuses. TAO Learning Specialists are on each of the satellite campuses one day per week. The student should inform the TAO team member if they have a campus preference.

Information regarding the Accessibility Office (TAO), accommodations and assistive technology (AT) at Bucks County Community College can be found at https://www.bucks.edu/resources/campusresources/accessibility/. Please visit our website for the latest information and updates as they are made available. If you have any questions, please feel free to call us (215) 968-8182.