Verification Form

Neurological Disorders

Bucks County Community College | Accessibility

Bucks County Community College's Accessibility Office (TAO) has established the Verification Form for Neurological Disorders to obtain current information from a qualified practitioner (e.g., licensed physician, neurologist, clinical psychologist, or neuropsychologist) regarding a student's hearing 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 neurological reports, neuropsychological evaluations, or secondary school documentation. Any documentation, including this Verification Form, must meet Bucks County Community College's TAO guidelines for Neurological Disorders.

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 neurological disorders is as follows:

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

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 neurological impairment? ☐ **YES** ☐ **NO**

Approximately at what age did the student start to exhibit neurological impairment symptoms? _____

What date was the student diagnosed with neurological symptoms? _____ Month _____ Year

2. Diagnosis, Condition and Symptoms

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

ICD 10 Code	Diagnosis

b. How long has the student had this disorder? _____

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

1) Please explain the severity checked above:

d. 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:

e. Current Symptoms

1) What is the date of the student's most current neurological assessment? _____ Month _____ Year

Please attach a copy of the most recent neurological assessment.

2) 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**

- If yes, please list the name of the neurological diagnostic test and/or neuropsychological evaluation that was completed?

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

f. Is the neurological impairment expected to remain stable or is it expected to decline? ☐ **Stable** ☐ **Decline**

1) Is the condition expected to decline? Please describe the expected progression of the specific neurological impairment.

g. Is there clear evidence that the symptoms associated with the neurological 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:	

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

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

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

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

3. 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 neurological 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? _____

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: _____

C. Student's History:

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

D. Family History:

1. Does the student have a family history of physical health or neurological 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.

E. Assistive Technology and Durable Medical Equipment:

1. Does the student use assistive technology? ☐ YES ☐ NO
   a. If yes, please list the assistive technology.
2. Does the student use durable medical equipment? ☐ YES ☐ NO
   a. If yes, please list the durable medical equipment.

F. 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., Rizatriptan 5 mg as needed):	
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.):	

G. Functional Limitations and Recommended Accommodations:

1. Please list the student's current neurological symptoms and then indicate what reasonable academic accommodations would mitigate the symptom listed.

2. **Sample:**

Symptom: (Example)
A student may have a seizure and experience prolonged fatigue afterward, causing difficulty taking a scheduled exam.
Recommended Reasonable Accommodation(s):
Opportunity to reschedule exams/quizzes

Symptom:
Recommended Reasonable Accommodation(s):

Symptom:
Recommended Reasonable Accommodation(s):

Symptom:
Recommended Reasonable Accommodation(s):

Symptom:
Recommended Reasonable Accommodation(s):

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 physician, neurologist, clinical psychologist, or neuropsychologist). 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 at (215) 968-8182.