Bucks County Community College

Verification Form

Neurological Disorders

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., physician, neurologist, and neuropsychologist) regarding a student's neurological disorder, associated symptoms, related medications, and their 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 hearing impairments can be found at the following web site: http://www.bucks.edu/student/accessibility/student-info/. 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:** _____

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: _____

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

B. Diagnosis Information:

1. What is the student's diagnosis?

2. When was the student diagnosed with the condition?

Month _____ Year _____

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

a. Explain the severity checked above:

4. 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):	☐

c. Explain the duration checked above:

5. Current Symptoms:

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

b. 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?

Environmental Functioning:	
School functioning:	
Social functioning:	
Work functioning:	

c. 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**

d. 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.

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

f. DSM Codes

Please include all pertinent diagnoses or rule-out diagnoses using DSM codes.	
Axis I:	
Axis II:	
Axis III:	
Axis IV:	
Axis V (GAF):	

g. ICD-10-CM Diagnosis Codes:

Please include all pertinent diagnoses or rule-out diagnoses using ICD-10-CM codes.

C. Student's History:

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

D. Medications:

1. Is the student currently taking medication(s) for any symptoms related to the diagnosis? ☐ **Yes** ☐ **NO**
2. 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 (e.g., Adderall 5 mg 1 x daily):	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication • Dosage • Frequency (e.g., Keppra 1000 mg 2 x daily):	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication • Dosage • Frequency (e.g., Keppra 1000 mg 2 x daily):	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

D. Functional Limitations and Recommended Accommodations:

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

2. **Sample:** student may have a seizure and experience prolonged fatigue afterward causing difficulty taking a scheduled exam.

Symptom: (Example)
Seizures followed by fatigue
Recommended Reasonable Accommodation(s):
Opportunity to reschedule exams/quizzes

Symptom:
Recommended Reasonable Accommodation(s):

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 physician, neurologist, and neuropsychologist). The provider signing this form must be the same person answering the above questions.

Provider's Name: _____
Last First Middle

Credentials: _____

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

Phone Number: _____ **Email:** _____

Practice Street Address: _____

_____

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

May this completed Verification Form be released to the student? ☐ **Yes** ☐ **NO**

Provider Signature: _____ **Date:** _____

Section IV: Submitting this Form

This form should be returned to the Accessibility Office (TAO) at Bucks County Community College where the student is enrolled. All forms need to be submitted at the Newtown campus. Please see the following methods of submission of this form:

Email: accessibility@bucks.edu

Fax: (215) 968-8033

USPS: Bucks County Community College
Attention: The Accessibility Office
275 Swamp Road
Newtown, Pennsylvania 18940

Physical Drop Off: Newtown Campus
Rollins Center • Student Services Office • Room 001

Information regarding the Accessibility Office (TAO) at Bucks County Community College can be found at http://www.bucks.edu/student/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.