PennState Educational Equity | Student Disability Resources

Student Disability Resources
The Pennsylvania State University
equity.psu.edu/sdr

VERIFICATION FORM for NEUROLOGICAL DISORDERS

Penn State's Student Disability Resources (SDR) office has established a 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 neurological disorder, associated symptoms, related medications, and their impact on the student, and their 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 Penn State's SDR guidelines for neurological disorders.

A summary of the guideline criteria for documenting neurological disorders is listed below (more information related to SDR documentation and guidelines for neurological disorders can be found at the following website: Link to Guidelines for Neurological Disorders).

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

I. Student Information: **(Please Print Legibly or Type)**

Student's Name:

First: _____

Middle: _____

Last: _____

Date of Birth: _____ PSU ID #: _____

Penn State campus student is attending: _____

Student's Home Address:

Street: _____

City: _____

State: _____

Zip: _____

Phone Number: _____

II. Provider Section:

1. Contact with Student

a. Date of initial contact with student:

b. Date of last contact with student:

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

2. Diagnosis

a. What is the student's diagnosis?

b. How long has the student had this disorder?

c. What is the severity of the disorder? Mild Moderate Severe

i. Explain the severity checked above:

d. What is the expected duration of the disorder? Chronic Episodic Short-term

i. Explain the duration checked above:

e. Current Symptoms:

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

ii. 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?

School functioning:	
Social functioning:	
Work functioning:	

iii. 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 ☐

iv. 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*.

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

f. ***DSM-5* Codes**:

i. Please include all pertinent diagnoses or rule-out diagnoses using *DSM-5* codes.

Principal Diagnosis: _____

Code: _____

Severity or Level of Impairment: _____

Descriptive Features: _____

Course: _____

Other Diagnoses: _____

Code: _____

Severity or Level of Impairment: _____

Descriptive Features: _____

Course: _____

WHODAS 2 Score (If given): _____

3. Student's History

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

4. Medications

a. Is the student currently taking medication(s) for symptoms associated with the neurological disorder?

Yes ☐ No ☐

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

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.):	

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.):	

5. Functional Limitations and Recommended Accommodations

a. Please list the student's current symptoms associated with the neurological disorder and indicate what reasonable academic accommodations would mitigate the symptom listed. More detailed information regarding reasonable academic accommodations can be found on the SDR website at: http://equity.psu.edu/sdr/applying-for-services/reasonable-accommodations

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

Symptom:
Recommended Reasonable Accommodation(s):

Symptom:
Recommended Reasonable Accommodation(s):

Symptom:
Recommended Reasonable Accommodation(s):

III. Provider's Certifying Professional Information:

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

Provider's Name:

First:

Middle:

Last:

Credentials:

License Number:

State of Licenser:

Street Address:

City:

State:

Zip:

Phone Number:

Email Address:

Can this completed Verification Form be released to the student? Yes ☐ No ☐

Signature of Provider: Date:

Submitting this Form:

This form should be returned to the disability office at the Penn State campus where the student is enrolled. Information regarding other Penn State disability offices can be found at: Campus Disability Coordinators. Please visit the SDR website and submit to the appropriate Penn State campus.