# Disability Verification Form for Traumatic Brain Injury (TBI)

Purpose: The student named below has indicated that s/he has a disability and will require reasonable accommodations to participate in a program or activity at Kean University. The information you provide will be one of the criteria used to evaluate the student’s eligibility for the requested accommodations or services. Please complete this form in its entirety. All information provided will be kept confidential in accordance with the Family Educational Rights and Privacy Act (FERPA).

## **Student Information:**

|  |  |
| --- | --- |
| Student’s First Name: |  |
| Student’s Last Name:  |  |

## The remainder of this document must be completed by a certified/licensed Health Care Provider.

Date of First Diagnosis: Click or tap to enter a date.

Date Student was first seen: Click or tap to enter a date.

Date Student was last seen: Click or tap to enter a date.

## **TBI Information**

In order to help this student adapt to college life after his/her injury, please supply (in as much detail as possible) answers to the questions that follow. Please complete all items which you have a history or have assessed in the course of clinical evaluation. If you wish to, please attach any relevant reports. At the end of this form, please hit submit and attach any items.

Date of Injury: Click or tap to enter a date.

|  |  |
| --- | --- |
| Number of Concussions **with** loss of consciousness: |  |
|  |  |
| Number of Concussions **without** loss of consciousness: |  |
|  |  |
| Date(s) without loss of consciousness: |  |

Were there any hospitalizations associated with any of these injuries? [ ] Yes [ ]  No

Were there any surgeries required as a result of any of these injuries? [ ] Yes [ ]  No

If you answered yes to any of the above, please provide details here:

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |

## **Post-Concussive Status**

Indicate all conditions present now: (Check all that apply)

|  |  |
| --- | --- |
| [ ] Fatigue  | [ ] Amnesia |
| [ ] Attention Problems | [ ] Confused Periods |
| [ ] Balance Problems | [ ] Seizures |
| [ ] Dizziness | [ ] Personality Change |
| [ ] Noise Sensitivity | [ ] Irritability |
| [ ] Light Sensitivity | [ ] Behavioral Problems |
| [ ] Headaches | [ ] Anxiety |
| [ ] Sleep Problems | [ ] Depression |
| [ ] Memory Problems | [ ] Suicidal Tendencies |
| [ ]  Other:  |  |

Please check if any or all of the following were done and provide the reports:

[ ] Skull X-ray

[ ] EEG

[ ] CT/MRI

[ ] SPECT

Check all that apply if there is any prior history of:

[ ] Special Education

[ ] Learning Disability

[ ] ADD/ADHD

[ ] Meningitis/Encephalitis

[ ] Substance/Alcohol abuse

[ ] Psychiatric/Psychological counseling

Please provide as attachments, any reports from neuropsychological/educational testing relating to TBI or any items listed in the section above.

## **Medication**

Is the student currently taking any medication? [ ]  Yes [ ]  No

If yes, please provide information on each medication below:

 (e.g., Celebrex, 200 mg, 1x daily, 1/1/2020, Dr. John Doe)

Medication 1, Dosage, & Frequency

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication Name** | **Dosage** | **Frequency** | **Date Prescribed** | **Prescribing Physician** |
|  |  |  |  |  |
| Side effects that impact the student’s functioning (e.g., concentration, sleep, thinking, eating, etc.): |
|  |
|  |

**Medication 2, Dosage, & Frequency**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication Name** | **Dosage** | **Frequency** | **Date Prescribed** | **Prescribing Physician** |
|  |  |  |  |  |
| Side effects that impact the student’s functioning (e.g., concentration, sleep, thinking, eating, etc.): |
|  |
|  |

**Medication 3, Dosage, & Frequency**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication Name** | **Dosage** | **Frequency** | **Date Prescribed** | **Prescribing Physician** |
|  |  |  |  |  |
| Side effects that impact the student’s functioning (e.g., concentration, sleep, thinking, eating, etc.): |
|  |
|  |

**Medication 4, Dosage, & Frequency**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication Name** | **Dosage** | **Frequency** | **Date Prescribed** | **Prescribing Physician** |
|  |  |  |  |  |
| Side effects that impact the student’s functioning (e.g., concentration, sleep, thinking, eating, etc.): |
|  |
|  |

## **Functional Limitations**

Please comment on the particular problems that may impair this student's functioning in the post-secondary school environment (e.g. the students/patient has difficulty functioning in the morning) and elaborate on present symptoms checked in the post-concussive status.

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |

## **Rancho Los Amigos Scale-Revised (RLAS-R)**

The Rancho Los Amigos Scale-Revised (RLAS-R) is a ten level descriptive scale that provides a standardized measure to understand a brain injury patient's abilities, impairments, and prognosis.

Please indicate with a [x]  the student’s history and current level of progress on the RLAS-R scale and date of assessment:

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Level I  | Level II | Level III | Level IV | Level V | Level VI | Level VII | Level VIII | Level IX | Level X |
|[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Click or tap to enter a date. | Click or tap to enter a date. | Click or tap to enter a date. | Click or tap to enter a date. | Click or tap to enter a date. | Click or tap to enter a date. | Click or tap to enter a date. | Click or tap to enter a date. | Click or tap to enter a date. | Click or tap to enter a date. |

**Health Care Provider Completing this form:**

Role of the individual completing this form (check all that apply).

|  |  |
| --- | --- |
| [ ]  Medical Doctor  | [ ]  Evaluator  |
| [ ]  Psychotherapist  | [ ]  Second Opinion Evaluator  |
| [ ]  Medication Supervisor  |  |
| [ ]  Other:  |  |

|  |  |
| --- | --- |
| Provider Full Name:  |  |
| License Number:  |  |
| Title/Profession:  |  |
| Street Address:  |  |
| City, State, Zip |  |
|  |  |
| Phone Number:  |  |
| Fax Number:  |  |
| E-mail Address: |  |

|  |  |
| --- | --- |
| Provider Signature: |  |

Today’s Date: Click or tap to enter a date.

**PROVIDER - You MUST attach a blank prescription form and/or an office stamp for authentication. The form is NOT authenticated without a stamp or script.**

**PROVIDER AND STUDENT - Unless proper documentation and AUTHENTIC SCRIPT OR OFFICE STAMP is provided, the Kean University Office of Accessibility Services cannot implement services for this student. Please contact us with any questions at (908) 737-4910 or** **accessibilityservices@kean.edu**

**Please return this form to:** **accessibilityservices@kean.edu** **or to:**

**Office of Accessibility Services**

**Downs Hall Room 122**

**Kean University**

**1000 Morris Avenue,**

**Union, NJ 07083**