



ACCESSIBILITY AND DISABILITY RESOURCE CENTER  
*The UNIVERSITY of OKLAHOMA*

Accessibility and Disability Resource Center  
300 Kellogg Drive  
Norman, Oklahoma 73072  
Office: (405) 325-3852  
Fax: (405) 325-4491

[adrc@ou.edu](mailto:adrc@ou.edu)  
[ou.edu/adrc](http://ou.edu/adrc)

**DISABILITY/DIAGNOSIS DOCUMENTATION FORM**

Dear Treating Professional:

You will find a signed release at the top of the enclosed Disability/Diagnosis Documentation Form authorizing the Accessibility and Disability Resources Center to receive medical information on your patient. This information is necessary to determine if the student has a qualifying disability which is substantially limiting in one or more daily life activities and to determine specific academic accommodations and other services the student may be eligible for while enrolled as a student at the University of Oklahoma.

Please complete the enclosed Disability/Diagnosis Documentation Form and return to the address provided on the letterhead. If you have questions regarding this request, please contact me at (405) 325-3852. Thank you for your cooperation. Your prompt reply will enable us to process this student's eligibility in a timely manner.

Sincerely,

Jennifer Murchison, Director



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**DISABILITY/DIAGNOSIS DOCUMENTATION FORM**

**Release of Information:**

I hereby authorize \_\_\_\_\_ to release the medical information requested herein to Accessibility and Disability Resource Center of the University of Oklahoma for the purposes of determining my eligibility for disability related services and/or academic accommodations.

Print Name: \_\_\_\_\_ ID: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ DOB: \_\_\_\_\_

**Disability/Diagnosis Information: To be filled out by Treating Professional (Please type or Print Legibly)**

Provider Name: \_\_\_\_\_

Credentials: \_\_\_\_\_

**Please answer the following questions as completely as possible.**

1. Are you the treating professional of this patient? Yes No

2. How long have you treated this patient? \_\_\_\_\_

3. Date of last visit: \_\_\_\_\_ Frequency of visits: \_\_\_\_\_

4. Medical Diagnosis(es): Please include the Diagnosis AND the DSM-IV-TR or DSM-5 codes:

<b>Diagnosis:</b>	<b>Date of Onset:</b>	<b>Expected Duration:</b> Permanent, Temporary, or Remitting/Relapsing	<b>Prognosis:</b> Progressive, Stable or Guarded

5. Has the patient been hospitalized for any of the above condition(s) within the past year?    Yes    No

If yes, please specify:

6. What medication(s) are currently prescribed for this patient? Please indicate below.

<b>Medication</b>	<b>Dosage</b>	<b>Side effects experienced by patient (if applicable)</b>

7. What other medical treatment, therapies, devices, or regimens have been prescribed for this patient?

8. Is the patient compliant with prescribed medication and/or treatment?  
Yes No. If No, please explain:

9. Please indicate the ***current disability related functional limitation(s)*** of the patient: (Select all that apply)

Functional Limitation	Description	Degree of Limitation		
Hearing		Mild	Moderate	Severe
Vision		Mild	Moderate	Severe
Speech		Mild	Moderate	Severe
Manual Dexterity		Mild	Moderate	Severe
Ambulation		Mild	Moderate	Severe
Motor Coordination		Mild	Moderate	Severe
Activities of Daily Living		Mild	Moderate	Severe
Endurance		Mild	Moderate	Severe
Respiration		Mild	Moderate	Severe
Climate/ Environment		Mild	Moderate	Severe
Concentration		Mild	Moderate	Severe
Memory		Mild	Moderate	Severe
Information Processing		Mild	Moderate	Severe
Social Interaction		Mild	Moderate	Severe

10. Please list any specific academic accommodations or other services you recommend to address the functional limitations you identified above:

11. Do you have specialty evaluations or reports (e.g., neuropsychological, psychiatric, visual, hearing, speech, physical therapy, occupational therapy, etc.) on this patient? Yes No If yes, please include a copy.

12. Please use this additional space to provide any other information you believe will be helpful to us in assisting your patient in their academic endeavors at the University:

Professional's Signature

Date

Professional's Telephone Number