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
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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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:

Diagnosis:	**Date of Onset:**	**Expected Duration:** Permanent, Temporary, or Remitting/ Relapsing	**Prognosis:** 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.

Medication	**Dosage**	**Side effects experienced by patient (if applicable)**

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

_____

Alternate Contact Person for Professional (Front desk, nurse, etc.)

_____

Alternate Contact Telephone Number