THE CATHOLIC UNIVERSITY OF AMERICA

Clinician Care Provider Documentation Form

(to be completed by the treating Clinician/Provider)

PLEASE TYPE OR PRINT CLEARLY

Student's First and Last Name:_____ **DOB:**_____

Diagnosis (Description and ICD-10-CM Code): _____

_____

_____

Date diagnosed:_____ **Date student was last seen:**_____

Duration student has been under your care? (Start/End Month/Year):_____

Provide detailed information regarding the student's diagnosis, including present symptoms and the symptoms' duration, severity, and overall impact on functions in an educational environment.

_____

_____

_____

Is the diagnosis changing or unchanging?_____

If changing, describe the anticipated progression:_____

_____

_____

Is the diagnosis chronic (Y/N)?_____ **If not, length of anticipated recovery:**_____

How did you arrive at your diagnosis/diagnoses? Please check all relevant items below; adding brief notes that you think might be helpful to aide in a possible determination of accommodations and services for the student:

Behavioral Observations □	Developmental History □	Other □
Interviews with other Persons □	Medical History □	_____
Medical Tests □	Un/Structured Interviews □	_____

_____

_____

Office of Disability Support Services

620 Michigan Ave., N.E. | Washington, DC 20064 | 202-319-5211 | 202-319-5126 (FAX) |
cua-dss@cua.edu | dss.catholic.edu |

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Within the chart below, indicate ways in which the student currently experiences functional limitations as a result of their diagnosed disability or condition. Use the below rating scale to indicate the level of limitation (if applicable).

1= Unable to Determine 2= No Impact 3= Mild Impact 4= Moderate Impact 5= Substantial Impact

1	2	3	4	5	Major Life Activities	1	2	3	4	5	Learning/Time Management
					Caring for self						Memory
					Talking						Concentrating
					Hearing						Listening
					Breathing						Organization
					Seeing						Managing distractions
					Walking						Adherence to deadlines
					Standing						Making and keeping appointments
					Lifting/Carrying						Managing stress
					Sitting						Reading
					Performing Manual Tasks						Writing
					Eating						Spelling
					Working						Math/Calculations
					Interacting with others						Performance based skills
					Sleeping						Processing speed
					Other (Please indicate)						Other (Please indicate)

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Is the student currently taking medication(s) for this issue (Y/N)?_____ If yes, what medication(s) is the student currently taking? For each medication, indicate any side effects and any impact on academic performance (if applicable).

Medication	Side Effects	Impact on Academic Performance

Describe both current and relevant past treatment plans, and address their effectiveness.

_____

_____

_____

What is the current recommended frequency of any ongoing care?

Once weekly Once monthly Every 3-4 months Every 6 months

Once annually As needed Other:_____

Is there anything else that is important to know about the student's disability or condition?

_____

_____

_____

Provider Name:_____ **Title:**_____

Signature:_____

Credentials:_____ **License #:**_____ **State:**_____

Professional Address:_____

City, State, Zip, Country:_____

Office Phone:_____ **Email Address:**_____

Date Completed:_____

Updated July 2022

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