THE CATHOLIC UNIVERSITY OF AMERICA

Clinical Care Provider Documentation Form

The Office of Disability Support Services (DSS) with The Catholic University of America provides programs and services designed to support and encourage the integration of students with disabilities into the mainstream of the University community. DSS assists in creating an accessible University community, where students with disabilities have an equal opportunity to fully participate in all aspects of the collegiate experience: in the academic environment as well as with campus life.

The below student has submitted an Accessibility Request to DSS. Supportive documentation from a qualified provider assists DSS in formulating a comprehensive understanding of a student's diagnosed disability or condition; to identify what barriers, challenges, or functional limitations may impact a student's experience; and to comprehend what care and treatment is being provided. Submission of supportive documentation is part of an interactive process with the student, through which DSS determines whether accommodations are appropriate and reasonable. It is not expected that the clinician provides recommendations on possible accommodations. Please complete this form in a timely manner and return it back to the student for submission directly to DSS.

TO BE COMPLETED BY THE STUDENT:

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

CUA Student ID Number:_____ **Student's CUA Email:**_____

The DSS Accessibility Request submitted seeks consideration for (select all that apply):

□ Academic Accommodations □ Housing Accommodations □ Dining Accommodations

It is advised that the clinician consider the above selection(s) when providing context about the student's diagnosed disability or condition.

TO BE COMPLETED BY THE DIAGNOSING CLINICIAN OR PROVIDER:

IF MULTIPLE CLINICIANS HAVE DIAGNOSED AND/OR PROVIDED CARE AND TREATMENT, IT IS RECOMMENDED THAT EACH CLINICIAN SUBMIT A SEPARATE DOCUMENTATION FORM

PLEASE TYPE OR PRINT CLEARLY

Provider Name (print):_____ **Title:**_____

Signature:_____

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

Professional Address:_____

City, State, Zip, Country:_____

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

Date Completed:_____

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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Diagnosis: List all diagnosis of the student relevant to this request and the initial date of diagnosis (Month/Year) for any/each disability or condition.

_____

_____

_____

_____

_____

What is the duration student has been under your care (Month/Year)? From:_____**To:**_____

What date was the student last seen for an examination/appointment (Month/Year):_____

Provide detailed information regarding the student's diagnosis, including symptomology and the observed and/or reported duration, severity, and overall impact the disability or condition has on major life functions and activities.

_____

_____

_____

_____

_____

_____

How did you arrive at your diagnosis? Check all relevant items below that informed your diagnosis, adding any brief notes that you think might be helpful to aid DSS in a possible determination of reasonable accommodations for the student.

Behavioral Observations □ Developmental History □ Interviews with other Persons □

Medical History □ Medical Tests □ Un/Structured Interviews □

Other □ _____

_____

Is the diagnosed disability or condition chronic? Progressive (likely to worsen over time)? Below please provide context about the nature of each diagnosed disability or condition indicated on this form. Comment on an anticipated recovery (if not chronic) or an anticipated progression (if progressive) based on current assessments.

_____

_____

_____

_____

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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: 1 = Unable to Determine/Did Not Evaluate; 2 = No Impact Determined; 3 = Mild Impact; 4 = Moderate Impact; and 5 = Substantial Impact.

1	2	3	4	5	**Major Life Activities**	1	2	3	4	5	**Learning and Executive Functions Skills**
					Breathing						Concentrating
					Caring for Self						Keeping Appointments
					Eating						Language Acquisition
					Hearing						Listening
					Interacting with Others						Managing Distractions
					Lifting/Carrying						Managing Stress
					Performing Manual Tasks						Math/Calculations
					Seeing						Meeting Deadlines
					Sitting						Memory
					Sleeping						Organization
					Standing						Processing Speed
					Talking						Reading
					Walking						Spelling
					Working						Writing
					Other (Please indicate)						Other (Please indicate)
					Other (Please indicate)						Other (Please indicate)

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Is the student taking any medication as part of their care and treatment for this disability or condition? List any medication prescribed (if applicable); for each indicate any relevant side effects, and provide insights on the overall effectiveness.

Medication	Relevant Side Effects (if applicable)?	Effectiveness?

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

_____

_____

_____

_____

_____

_____

What is the current recommended frequency of any ongoing or continued care?

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

Once annually □ As needed □ Other:_____

Is there anything else not explicitly addressed on this form that is important for DSS to know about the student's disability or condition?

_____

_____

_____

_____

_____

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Clinical Care Provider Documentation Form

Allergy and/or Prescribed Diet Addendum

This Allergy and/or Prescribed Diet Addendum must accompany a completed Clinical Care Provider Documentation Form if and only if a student's diagnosed disability or condition is related to the presence of an allergen(s) and/or the need for a modified, prescribed diet. This Addendum does not need to be returned to DSS if the questions contained on it do not apply to the student's diagnosed disability or condition, or relevant to their submitted request.

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

TO BE COMPLETED BY THE SAME DIAGNOSING CLINICIAN/PROVIDER:

PLEASE TYPE OR PRINT CLEARLY

Please complete the following chart to report any allergens confirmed by diagnostic tests. If Environmental or 'Other' is identified below, please specify the allergen in the space provided.

Allergen	Not Allergic	Mode: Airborne	Mode: Contact	Mode: Ingestion	Allergic Reaction
Milk/Dairy					
Eggs					
Fish					
Shellfish					
Tree Nuts					
Peanuts					
Grains					
Soybeans					
Sesame					
Environmental _____					
Other _____					

DSS requires that a comprehensive allergy test report and a clinical interpretation of the report be provided along with this addendum.

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Has the student been prescribed with any medication (including use of an Epi-Pen) and/or any immunotherapy treatment to address their allergies? If yes, please describe in detail below.

Has the student been prescribed a diet and/or referred to work with a Licensed Nutritionist? If yes, please describe in detail below.

DSS requires a comprehensive list of food/ingredients that the student must avoid and a list of foods/ingredients that the student should consume to adhere to the parameters of a prescribed diet also be provided along with this addendum. This additional documentation can be provided either by the Clinician completing this form or come separately from a referred Licensed Nutritionist.

The Catholic University of America strongly believes in the benefits that a structured meal plan program and on-campus living has to offer to our students in terms of academic success; personal development; campus community involvement; overall nutrition, health and wellbeing; and in the importance of a shared, communal experience. The Catholic University of America requires that all first-, second-, and third-year undergraduate students live in on-campus housing and participate in the meal plan program (limited exclusions may apply). The additional information in this Addendum is often needed when DSS is evaluating requests for housing and/or dining accommodations.

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