NOTE:

This form can NOT be used for

ADD/ADHD
or
Psychiatric Disorders
(Depression, Bi-Polar, Anxiety Disorder, etc.)
or
Learning Disabilities

Please be aware that additional documentation may be required by Disability Services

For more information on documentation requirements and guidelines for the above disorders and others visit http://www.utsa.edu/disability.

The University of Texas at San Antonio

Disability Services

www.utsa.edu/disability

One UTSA Circle
San Antonio, TX 78249-0690
210-458-4157 (main)
210-458-2945 (downtown)
210-458-4980 (Fax)

Disability Documentation Form for Students with Mobility Impairments and Other Functional Limitations due to Medical Conditions

Date:_____

Name of Student:_____

Dear Medical Professional:

The student whose name appears above has applied for disability services/accommodations at Disability Services (DS) at the University of Texas at San Antonio (UTSA). In order for the DS to establish whether this student has a disability and to determine his/her eligibility for services, we will need your clinical assessment/diagnosis of this student. A disability is defined as **a physical or mental impairment that substantially limits** one or more major life activities such as those delineated below. You can fax or mail this form to DS using the contact information listed above. Thank you for you time and assistance in this matter.

1. Is the patient/student currently under your care? If yes, for how long?

2. What is the diagnosis/impairment/condition? (Please describe and use ICD 10 diagnostic codes)

3. Date diagnosis was made:

4. When did you last see the patient/student?

5. Major Life Activities Assessment: (Note: If testing was completed to diagnose the condition, please attach any supporting information, e.g., neurological or psycho-educational test reports, etc.)

Please check which of the **major life activities** listed below are affected in a learning environment because of the impairment/condition and please indicate the level of limitation.

Life Activity	**1 - Negligible**	**2 - Moderate**	**3 - Substantial**
Speaking	☐	☐	☐
Walking	☐	☐	☐
Breathing	☐	☐	☐
Standing	☐	☐	☐
Reaching	☐	☐	☐
Lifting	☐	☐	☐
Sitting	☐	☐	☐
Hearing as it relates to the medical condition you are treating	☐	☐	☐
Seeing as it relates to the medical condition you are treating	☐	☐	☐
Performing Manual Tasks	☐	☐	☐
Writing as it relates to the medical condition you are treating	☐	☐	☐
Sleeping as it relates to the medical condition you are treating (e.g. due to seizure activity)	☐	☐	☐
Concentrating as it relates to the medical condition you are treating	☐	☐	☐
Memorizing as it relates to the medical condition you are treating	☐	☐	☐
Reading as it relates to the medical condition you are treating	☐	☐	☐
Caring for Oneself	☐	☐	☐
Other (please specify)	☐	☐	☐

6. What are the **specific functional limitations** resulting from the impairment's impact on the major life activities in a learning environment identified above (e.g., unable to attend classes due to side effects from condition or medication; difficulty ambulating distances between classes; unable to keyboard more than 10 minutes out of 60 minutes)?

7. Are the functional limitations permanent? If not, anticipated date of resolution? Prognosis?

8. List any medications and described effects and possible side-effects on the medical condition you are treating:

9. If student is currently undergoing treatment (e.g. chemo therapy) please describe the treatment and how this treatment may affect the student in a post-secondary setting.

Note: Tests of cognition, information processing and academic achievement, which may not be part of the diagnostic process itself, may be needed by DS to determine appropriate academic accommodations and services for a student with a mobility impairment or other impairment due to a medical condition.

_____ _____

Signature of Medical Professional Date

_____ _____

Medical Professional's Name (printed) License No.

_____ _____

Address Telephone No.

_____ _____

Fax No.

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