Disclosure Form – Hearing Loss
Information for clinicians

You are receiving the attached Disability Disclosure Form - Hearing Loss - because a student under your care is requesting accommodations from the Disability Resource Center (DRC) at Northeastern University.

A diagnosis of a hearing loss does not, in and of itself, qualify a student for accommodations under the ADAAA. Accommodations are not based on the student's diagnosis, but instead are designed to address the barrier(s) caused by any substantial limitation(s) related to the disorder. Accommodations are meant to allow full participation in academic and university life for students with disabilities; they do not guarantee student success. The DRC uses a multi-source process to determine eligibility for disability-related accommodations, which includes self-report, history of accommodations (when available), and clinical observations. This form is intended to provide us with the latter.

Please note that the information you provide in response to the questions on this form must be current; in general, you must have seen the student within the last 6 months to meet this requirement. If you have recently begun treating this student, you may find that you do not yet have sufficient information to respond to the questions on this form. If you have not had recent clinical contact with the student, or otherwise find that you cannot effectively complete this form, please inform the student directly.

If you have questions or concerns about this form, how the information is used, or how best to support the student, we invite you to contact our office, at 617.373.2675 or email DRCDocumentation@northeastern.edu.

Disability Disclosure Form – Hearing Loss

Dear (Clinician Name)_____:

I am requesting services from the Disability Resource Center (DRC) at Northeastern University. In order to receive services, the DRC requires documentation of my disability. Services at the DRC are solely based on diagnostic documentation. Once this information is in place, it will be used to develop a service plan for me.

☐ I hereby authorize you to complete the enclosed Disclosure Form and release it to the DRC.

☐ I authorize you to attach a copy of my current audiology report, as requested.

☐ I also authorize you to speak with my DRC Specialist in consultation to provide future services.

Please submit the completed form by mail to:

Disability Resource Center
20 Dodge Hall
Northeastern University
360 Huntington Avenue
Boston, MA 02115

Or by confidential fax: 617-373-7800 or email DRCDocumentation@northeastern.edu

Thank you for your timely assistance with this matter.

Sincerely,

_____ _____
Student Signature Date

_____ _____
Print Name NU ID#

Disability Disclosure Form – Hearing Loss

This form must be completed by the licensed clinician or health care provider **who is treating this patient for the diagnosis identified** in this document. **Please attach the most recent audiology report.**

Please thoroughly complete this form to document the substantial limitations that are linked to this disability.

1. **Patient's/Client's Name**_____
2. **Diagnosis/Description of Disability:** _____
3. **Please provide full DSM or ICD---9 code:** _____
4. **Initial Date of Diagnosis:** _____
5. **Date of last clinical contact:** _____
6. **Expected duration of disability noted above is:**

☐ Permanent
☐ Chronic
☐ Long term (3---12 months)
☐ Short term (60-90 days)
☐ Temporary (1-60 days)

7. **Level of hearing loss is:** ☐ **Mild** ☐ **Moderate** ☐ **Severe** ☐ **Profound**
8. **Assessment Instruments and Results** (Please describe the procedures, assessment tools, etc. used to establish the diagnosis)**:**
9. **Please describe the student's history of difficulties with his/her disability. Please include both general and academic areas of impact.**
10. **Please describe the functional impact of the disability/symptoms on this individual's:**

Daily life (include any limitations related to personal care, social interactions, manual tasks, etc.)

Academic environment (note: please consider situations in and out of the classroom)

11. Please comment on the following items as applicable:

- **If Deaf---Blind, rate Mobility and Orientation** *(travel skills)*: **Novice Intermediate Advanced**
  (***Please include current vision evaluation report; see Disclosure Form for Blind/Vision Impairment***)
- **Communication method (indicate all that are used):**

☐ American Sign Language
☐ Signed English
☐ Other Signed Language (e.g. Spanish)
☐ Cued Speech
☐ Oral: English. Other Language: _____
☐ Tactile Sign Language
☐ Close Vision Signing
☐ Other : _____

- **This person uses any or all of the following (indicate specific device or service):**

☐ Hearing Aids
☐ Bilateral
☐ Unilateral
(type/model: _____)
☐ Cochlear Implant. Type: _____
Month/Year of surgery: _____

Month/Year of most recent map: _____

☐ Service Animal (Hearing Dog)
☐ Assistive Listening Device
☐ (please specify: _____)
☐ Other Technology/Aids
☐ (please specify: _____)

- **Suggested accommodation(s) for the academic setting:**

☐ Alternate Text Formats (Deaf---Blind)
☐ Assistive Listening Device
☐ Captioned Media
☐ Housing (circle any that apply)
Signaling: Visual and/or Vibration
Service Animal Relief Area
Other: _____

☐ Note---taking
☐ Oral Transliteration
☐ Preferential Seating
☐ Sign Language Interpreting/Transliterating
☐ Speech to Text Services
☐ Other: _____

- **Additional information:**

Clinician's Name: _____

Clinician's State Licensure/Certification #: _____

Area of Specialty: _____ **Clinician's phone #:** _____

_____ _____

Clinician's signature **Date**

NOTE: Please attach a current Audiology Report to this Disclosure For