Northeastern University

DISABILITY RESOURCE CENTER

360 Huntington Ave, **20 Dodge Hall**, Boston, MA 02115

Disability Disclosure Form – Chronic Disorder

Information for Clinicians

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

A diagnosis of a chronic disorder 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.

*Website: www.northeastern.edu/drc * Phone: (617) 373 2675 * Fax: (617) 373 7800*

Disability Disclosure Form – Chronic Disorder

Dear (Clinician Name)____ Date:_______________

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 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 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#

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Disability Disclosure Form – Chronic Disorder

This form is to be filled out by the clinician currently treating the student for the diagnosis(es) identified below. Please read the attached "Information for clinician" cover sheet before completing this form

Patient's/Client's name: ____

1. **Diagnosis/Description of disability:** ____
2. **Please provide full DSM or ICD-9 code:** ____
3. **Initial date of diagnosis:**________________________ 4. **Date of last clinical contact:** ______________
5. **The extent of the disability is:** ☐**Mild** ☐ **Moderate** **Severe**
6. **What is the frequency and duration of symptoms of the student's condition?**
   a. ☐Daily ☐ 1x/week ☐ 1-3x/week ☐ 1x/month ☐ 1-3x/year ☐Seasonal
   b. ☐None – symptoms under control with medication ☐Other: ___________________
7. **Assessment instruments used and results** (Please describe the procedures, assessment tools, etc. used to establish the diagnosis)**:**

8. **Please describe the student's history of difficulties with his/her disability. Please include both general and academic areas of impact.**

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9. **Please describe the *substantially* limiting symptoms which impacts this individual's functional abilities in the following areas:**

   a. **In the classroom or lab.** *Please describe the current impact of this student's disability on his/her ability to perform in-class or lab work. Please consider, as relevant, the impact on tasks including but not limited to: paying attention to lecture, taking notes, responding to oral or written questions, participating in group work, and following instructions.*

   The extent of these symptoms are: ☐Mild ☐ Moderate ☐ Severe

   b. **During exams/tests/quizzes/timed class work.** *Please describe the current impact of this student's disability on his/her ability to perform during testing or on timed work. Please consider, as relevant, the impact on tasks including but not limited to: maintaining concentration, disregarding distractions, organizing responses, and speed of responses.*

   The extent of these symptoms are: ☐Mild ☐ Moderate ☐ Severe

   c. **On individual or group work and assignments outside of class.** *Please describe the current impact of this student's disability on his/her ability to perform academic tasks outside of class. Consider, as relevant, the impact on tasks including, but not limited to: responding to oral or written questions, participating in group work, following instructions, maintaining concentration, disregarding distractions, and organizing responses.*

   The extent of these symptoms are: ☐Mild ☐ Moderate ☐ Severe

d. **On campus life** (include any limitations related to self/personal care, interactions with roommates /peers, non –classroom settings e.g. residence hall/dining hall social settings, etc.)
The extent of these symptoms are: ☐Mild ☐ Moderate ☐ Severe

10. **Please describe the current treatment and medication regimen** (including treating clinicians, frequency of treatment, medications, and side effects)**:**

11. **Additional information:**

Clinician's Name: ______________________________

Clinician's State Licensure/Certification #: ______________________________

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

______________________________ ______________________________
***Clinician* Signature** **Date**

Please note: the information in this form may need to be updated annually

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