Disabilities Functional Limitations Report

[Press the TAB key to move from field to field] [Do NOT use the ENTER key]

Name: _____ SSN: _____ DOB: _____

Release of Information:
I hereby authorize _____ to release the medical information requested herein to Student Disability Services at ASU Mid-South for the purposes of determining my eligibility for disability related services and/or academic accommodations.

Print Name: _____ Date: _____

Student Signature: _____

In order to provide appropriate accommodations for learning in the higher education setting, we need additional information about how the disability impacts this student's learning. Please attach copies of documentation supporting the diagnosis, its severity and prognosis.

Are you the primary care physician for this patient? ☐ Yes ☐ No

How long have you treated this patient? _____

Date of last visit: _____ Frequency of visits: _____

Physical Disability (diagnosis, description of impact on learning, and treatment)

_____

_____

_____

Psychological Disability/Learning Disability (If diagnosis is ADD, ADHD or a learning disability, please list tests completed, sub-scores, interpretation and recommendations.)

DSM IV Name	**Diagnostic Code**
Axis I _____	_____
Axis II _____	_____
Axis II _____	_____
Axis IV _____	_____
Axis V _____	_____

Please answer the following questions.

Does this individual's disability directly affect processing of information? If yes, how?

_____

Please check which of the following, if any, are affected significantly enough to have an impact in a higher education setting.

☐ Oral expression
☐ Written expression
☐ Auditory processing
☐ Concentration
☐ Perceptual distortions
☐ Delusions

If perceptual distortions or delusions occur, please explain further. _____

_____

Does the disability directly affect ability to attend class regularly? If yes, why?_____

_____

Does the disability cause a threat to safety of self or others? If yes, in what way? _____

_____

What medications does the individual take regularly and what side effects do these have that might significantly impact education? _____

_____

What accommodations would you recommend? Your specific recommendations are needed or academic changes to occur for this student.

☐ Extra time for test – Please be specific: ☐ Time and a half OR ☐ Double Time
☐ Note taker or access to instructor's notes ☐ Low distraction test side
☐ Tape recorder ☐ Assistive listening device
☐ Special Equipment Needed _____
☐ Other _____

Signature and information needed:

Certified Rehab Counselor CRC: _____

Print Name: _____

Signature of Licensed Professional: _____

Print Name: _____ **License Number:** _____

Office Name: _____ **Phone Number:** _____

Office Mailing Address: _____

RETURN COMPLETED FORM TO:
ASU Mid-South
Vice Chancellor for Student Affairs
2000 West Broadway
West Memphis, AR 72301
Fax: 870-733-6790
Or email completed form to egschlauch@midsouthcc.edu