Neurological Conditions Documentation Form

Student Name: _______________________________ DOB: _____ / _____ / _____ has requested support services from Accessible Educational Services (AES) at Indiana University Bloomington (IUB) regarding a neurological condition. Documentation provides vital information about the functional limitation of the student’s qualifying medical condition and its impact in a post-secondary academic environment.

Neurological disorders are numerous and refer to impairment of the nervous system, including the brain, spinal cord, nerves, and muscles. Examples of neurological disorders include, but are not limited to: cerebral palsy, seizure disorders, sleep disorders, Multiple Sclerosis, stroke, or traumatic brain injury.

Please complete all sections of this form and return it as soon as possible so that we may verify the student’s eligibility for services. Providers may also use their own documentation format if all the information requested below is included; if this information is not provided, services may be delayed as AES obtains clarification. Please call 812-855-7578 if you have questions. The completed form may be faxed to 812-855-7650 or it may be mailed to the address at the bottom of this page. AES welcomes any additional documentation you would like to include.

Diagnoses:
Primary: __________________________________________________________________________
Secondary: ________________________________________________________________________
Date of Diagnosis: ___/___/____ Initial visit: ___/___/____ Last appointment: ___/___/_____

Basis on which diagnosis was made:
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Clinical Manifestations or Current Symptoms:
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Characteristics of Neurological Condition: (Check all Appropriate Terms)
☐ Stable ☐ Slow Progressing ☐ Rapid Progressing ☐ Improving ☐ Mild ☐ Moderate ☐ Severe

Current medical treatment that may affect the student in the higher education environment.
___________________________________________________________________________________________
___________________________________________________________________________________________

Do the student’s symptoms fluctuate or worsen ☐ Yes ☐ No If yes, please explain:
___________________________________________________________________________________________
How long do you anticipate the condition impacting academic achievement? *(Check one)*

☐ < 6 months  ☐ < 1 year  ☐ > 1 year  

Prescribed medication and the side effects that impact academic functioning:

____________________________________________________________________________________  
____________________________________________________________________________________  

**Implications for Educational Success/Major Life Activities (REQUIRED):**

Please check which of the major life activities listed below are affected because of the diagnosis. *Substantial limitation is defined as a “significant restriction in the condition, manner, or duration in which a major life activity is performed compared to most people.”*

☐ Concentration*  ☐ Cognitive functioning*  ☐ Communication  
☐ Memory*  ☐ Processing speed*  ☐ Motor Skills  
☐ Sleeping  ☐ Walking  ☐ Lifting  
☐ Other __________  ☐ Other __________  ☐ Other __________

*Note: Appropriate psychometric data should be included for these areas of limitation.

Additional comments and recommended auxiliary support, strategies, or service that may be beneficial to the student in the higher education environment.

____________________________________________________________________________________  
____________________________________________________________________________________  
____________________________________________________________________________________  
____________________________________________________________________________________  
____________________________________________________________________________________  

Certifying Professional

Name *(print)*: _________________________________________________________ Date: ____/____/_____  
Profession: _____________________________________________ License number: _____________________  
Office Address: _____________________________________________________________________________  
Phone: ______________________ Fax: ______________________ Email Address: _____________________  
Certifying Professional Signature: _____________________________________________________________