Access Services for Students with Disabilities
Lesley University
11 Mellen Street
Cambridge, MA 02138
(617) 349-8194 voice
(617) 349-8544 TTY
(617) 349-8558 fax

Physical/Mobility Disability Disclosure Form

For Office Use Only

Date Received:

The licensed clinician or health care provider **who is treating this patient for the diagnosis identified** in this document **must** complete this form.

INCOMPLETE FORMS WILL DELAY POTENTIAL SERVICES

Student's Name: _____ Date: _____

Clinician's Name: _____

State Licensure/ Certification #: _____

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

Address: _____

The person named on this form is requesting services from Access Services for Students with Disabilities, which offers services to students who are considered disabled under the mandates of the Americans with Disabilities Act of 1990 (ADA). Under the ADA guidelines a person with a disability is one with a physical, mental, emotional or chronic health impairment that ***substantially limits*** one or more major life activity such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

- **I verify that the person named in this document has a substantially limiting disorder that meets the aforementioned ADA disability criteria: Yes ☐ No ☐**

If yes, please thoroughly complete this form to document the substantial limitations that are linked to this disorder.

1. Diagnosis/Description of Physical/Mobility Disability
Please provide full ICD code:

2. **The extent of the disorder is**: ☐ Mild ☐ Moderate ☐ Severe

3. **Initial Date of Diagnosis**: **4. Date of last clinical contact**:

5. Expected duration of disorder or disability noted above is:

☐ Permanent/ Chronic
☐ Long term: 3-12 months

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6. What is the frequency and duration of symptoms of the student's condition?

☐ Daily ☐ 1/week ☐ 1-3/week ☐ 1/month ☐ 1-3/year ☐ Seasonal

☐ None – symptoms under control with medication ☐ Other:

7. Assessment Instruments and Results: (Please describe the procedures used to establish the diagnosis):

8. Medications:

Current medications (dosage and side effects):

Long term medication plan:

Current compliance with medical plan:

9. History of hospitalization:

10. Describe the symptoms of this diagnosis that the student experiences:

Functional Impact

Please complete this section so that we may better serve this student in the Academic and Residential settings

Describe below how these symptoms substantially limit student's functioning in the academic and residence hall setting:

Wheelchair user ____ Manual ____Electric Drives an adapted van/car_____

Please list any other equipment that may used (i.e., Hoyer lift, transfer board, shower chair, etc. computerized environmental control units, service animals).

Does student use personal care assistance? Yes _____ No_____
If yes, how many hours per day_____

Please describe student's functional manual dexterity abilities/limitations in the following areas:

Personal care: Dressing, Bathing, Bowel and Bladder care

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Activities of daily living: Meal preparation, Eating, Housekeeping, Laundry

Maneuvering wheelchair

Manual Dexterity/Writing:

Please explain any program for physical therapy or treatment plans that student participates in during established class hours.

Are there any psychological issues or other adjustment concerns that would be helpful to support the student's academic experience here at Lesley University?

Is this student aware of any realistic limitations regarding how the physical/mobility disability may impact their academic performance?

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Suggested accommodations:

Additional information:

Clinician Signature: _____Date:_____

Revised 11/2016