

Disability Support Services

Lesley University
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**Hearing Loss Disability
Disclosure Form**

<u>For Office Use Only</u> Date Received:
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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 accommodations from Disability Support Services, which offers services to students who are considered disabled under the mandates of the Americans with Disabilities Act Amendments Act (ADAAA) revised in 2008. Under the ADAAA 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 ADAAA disability criteria: Yes No**

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

1. Description of the chronic or degenerative disorder or primary disability:

2. Initial Date of condition onset:

3. Date of last clinical contact:

4. Expected duration of disability noted above is:

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

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5. Level of hearing loss is: **Mild** **Moderate** **Severe** **Profound**

6. Assessment Instruments and Results (Please describe the procedures, assessment tools, etc. used to establish the condition):

8. Medications:

Current medications (dosage and side effects):

Long term medication plan:

Current compliance with medical plan:

9. History of hospitalization:

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

11. Is this student aware of any realistic limitations regarding how the hearing loss may impact their academic performance?

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:

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)

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Communication method (indicate all that are used):

- | | |
|---|--|
| <input type="checkbox"/> American Sign Language | <input type="checkbox"/> Oral English |
| <input type="checkbox"/> Signed English | Oral Other Language: _____ |
| <input type="checkbox"/> Other Signed Language (e.g. Spanish) | <input type="checkbox"/> Tactile Sign Language |
| <input type="checkbox"/> Cued Speech | <input type="checkbox"/> Close Vision Signing |
| | <input type="checkbox"/> Other: _____ |

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

- | | |
|---|--|
| <input type="checkbox"/> Hearing Aids
___ Bilateral
___ Unilateral
(type/model: _____) | <input type="checkbox"/> Service Animal (Hearing Dog) |
| <input type="checkbox"/> Cochlear Implant. Type:
Month/Year of surgery: _____ | <input type="checkbox"/> Assistive Listening Device
please specify: _____ |
| | <input type="checkbox"/> Other Technology/Aids
please specify: _____ |
| | Month/Year of most recent map: _____ |

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: _____

Additional information:

Clinician Signature: _____ Date: _____