Xavier University of Louisiana
Office of Disability Services
1 Drexel Drive – Box D **Office: (504)520-7315**
New Orleans, LA 70125 **Fax: (504)520-7943**

ODS Registration

1. Complete the **Registration Process** (see steps below) in the Patient Portal

Registration Process

- **Go to xula.edu**
- Hover over **Experience Xavier LA –** (a drop box will open)
- Click on **Center for Health & Wellness**
- Click on **Disability Services** (under the picture)
- Click on **Registration**
- Select the **Accommodation** tab, then select **Application**
- Complete the application and submit

If you have any documentation to submit, you may upload it with your application or email it to **disabilityservices@xula.edu**

If you have any questions or issues completing the Registration Process, please contact our office at **(504)520-7607** or email us at **disabilityservices@xula.edu**

Thanks,
Office of Disability Services

XAVIER UNIVERSITY OF LOUISIANA
Office of Disability Services
1 Drexel Drive ● Box 180
New Orleans, Louisiana 70125-1098
(504) 520-7607 ● FAX (504) 520-7947

CERTIFICATE OF DISABILITY

Office of Disability Services
Student Certificate of Disability Form

Dear Student,

This form is designed to provide The Office of Disability Services with confirmation that you have a disability and with information on how your disability will impact your studies at the university. See last page for more information on documentation for a learning disability, ADHD and psychiatric/psychological disabilities.

The mandate of The Office of Disability Services is to provide reasonable and appropriate academic accommodations while maintaining academic integrity of the degree. The Office of Disability Services will use the information provided by your health care provider to work with you to determine what accommodations you will need while you are studying. Please bring this form to a health care professional who knows you well.

Disclosing a mental health diagnosis is a choice and is **not** required to receive accommodations. Please indicate below if you give consent for your regulated health care provider to disclose your diagnosis.

This form must be completed by a qualified healthcare provider **(Health Care Providers must be certified/accredited** in one of the following categories: **MD, Ph.D., Psy.D., and LCSW)** and submitted to the Office of Disability Services.

ATTENTION STUDENT: This document, once completed by your qualified healthcare provider, should be submitted to the Office of Disability Services, located in the Convocation Center Annex – Room 215, or you can fax a copy to (504) 520-7947. **Remember, before your accommodation is approved all required forms and documentation must be received by the Office of Disability Services.**

ATTENTION HEALTH CARE PRACTITIONER: If you are preparing this form for a student registering with The Office of Disability Services, the student has a separate questionnaire that they must complete and submit to The Office of Disability Services**.** If you will be submitting this form directly to our office on behalf of the student, please mail to: **Disability Services, 1 Drexel Drive, Box 180, New Orleans, LA 70125-1098**

STUDENT INFORMATION

Date of Request _____ Semester: Fall ____ Spring ____Summer____ Year: _____ Date of Birth: ____ / ____ / ____

Student Name: _____ Student ID Number _____

Email: _____ Contact Phone Number: _____

What accommodations are you requesting? _____

_____

RELEASE OF INFORMATION (Please indicate below if you give consent for your healthcare provider to disclose your diagnosis)

I hereby authorize my Health Care Practitioner named here: _____ to share information concerning the functional impact(s) of my disability with The Office of Disability Services at Xavier University of Louisiana.

Student's Signature: _____ Date _____

CONSENT TO DISCLOSURE OF MENTAL HEALTH DIAGNOSIS TO THE OFFICE OF DISABILITY SERVICES

☐ I consent to my mental health diagnosis being identified on this form and provided to The Office of Disability Services at Xavier University of Louisiana.

☐ I do not consent to my mental health diagnosis being identified on this form.

Student's Signature: _____ Date _____

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CERTIFICATE OF DISABILITY

Student Name: _____ Student XULA ID Number: _____

Health Care Provider with Authority to Make a Relevant Diagnosis

You have been asked by a student who wishes to register with The Office of Disability Services at the Xavier University of Louisiana to complete the enclosed documentation. The Office of Disability Services supports students who **require academic accommodation for a permanent or temporary disability.** Interim accommodations may be provided for students being assessed for mental health disabilities.

The purpose of the documentation is to enable the Office of Disability Services to recommend reasonable and appropriate academic accommodations for students with disabilities who experience functional restrictions and limitations affecting their performance in academic classroom/lab. The post-secondary environment involves taking examinations, and generally assuming personal responsibility for one's higher education pursuits

We rely on your detailed knowledge of this student's disability, including a list of the functional limitations and restrictions that may impact on their learning and demonstrating their knowledge and skills.

Documentation must be provided by a regulated Health Care Practitioner licensed to diagnose.

HEALTH CARE PRACTITIONER INFORMATION

<table>
<tr><td colspan="2">Name of Health Care Practitioner
(please PRINT):</td><td colspan="4"></td></tr>
<tr><td colspan="3">Facility Name and address - <u>Please use official stamp</u>
Note: If you do not have an office stamp please sign and attach your letterhead. Signatures on prescription pads will NOT be accepted.</td><td colspan="3">Specialty:
❑ Audiologist
❑ Family Medicine
❑ Gastroenterologist
❑ Neurologist
❑ Neuropsychologist
❑ Neurosurgeon
❑ Occupational Therapist
❑ Ophthalmologist</td><td>❑ Optometrist
❑ Physiotherapist
❑ Psychiatrist
❑ Psychologist
❑ Rheumatologist
❑ Speech Language Pathologist
❑ Other regulated health practitioner:
_____</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td>Health Care Practitioner Signature:</td><td colspan="3"></td><td>Registration/ License No.</td><td></td></tr>
<tr><td>Date</td><td></td><td>Telephone Number</td><td></td><td>Fax Number</td><td></td></tr>
</table>

DISABILITY VERIFICATION

The provision of a diagnosis in the documentation is voluntary however, disability documentation must still confirm the student's type of disability and the functional limitations. If the student consents, please provide a clear diagnostic statement; avoiding such terms as "suggests" or "is indicative of". **If the diagnostic criteria are not present, this must be stated in the report.**

If the student does not permit the disclosure of the diagnosis, please verify that a disability is present. There will be some instances where a diagnosis is required to establish eligibility for specific support (e.g., funding).

Please note any multiple diagnoses or concurrent conditions.

Nature of Disability	**Primary Disability** *Indicate ONE only*	**Date of Diagnosis** Diagnosed by you ❒ Yes / ❒ No	**Reviewed other Documentation**	**Other Disability(ies)** *Indicate ALL that apply*	**Date of Diagnosis** Diagnosed by you ❒ Yes / ❒ No	**Reviewed other Documentation**
Acquired Brain Injury	❍		❍ Yes/ ❍ No	❍		❍ Yes/ ❍ No
Attention Deficit (Hyperactivity) Disorder	❍		❍ Yes/ ❍ No	❍		❍ Yes/ ❍ No
Autism Spectrum Disorder	❍		❍ Yes/ ❍ No	❍		❍ Yes/ ❍ No
Chronic Physical Illness	❍		❍ Yes/ ❍ No	❍		❍ Yes/ ❍ No
Deaf, Deafened, Hard of Hearing	❍		❍ Yes/ ❍ No	❍		❍ Yes/ ❍ No
Low Vision, Blind	❍		❍ Yes/ ❍ No	❍		❍ Yes/ ❍ No
Mental Health	❍		❍ Yes/ ❍ No	❍		❍ Yes/ ❍ No
Physical Mobility	❍		❍ Yes/ ❍ No	❍		❍ Yes/ ❍ No
Other*	❍		❍ Yes/ ❍ No	❍		❍ Yes/ ❍ No

Reminder: For ADD/ADHD, LD and psychiatric / psychological disabilities see documentation guidelines on pages 10 - 11. A regulated Health Care Practitioner may make an ADD/ADHD diagnosis.

Diagnosis: DSM / ICD (text and code) _____ **Date of Diagnosis: _____**

Date of Last Clinical Contact w/ Student _____

DURATION:

❒ ***Permanent* disability** with on-going (chronic or episodic) symptoms (that will impact the student over the course of their academic career and is expected to remain for their natural life).

❒ ***Temporary*** with anticipated duration from: _____/ _____/ _____ to_____/ _____/ _____ (Year, Month, Day).

If duration is unknown, please indicate reasonable duration for which the student should be accommodated/supported (please specify):_____ (number of weeks, months) **or term ending:** ❒ Spring ❒ Summer ❒ Fall

❒ Must be reassessed every _____ due to the changing nature of the illness or requires follow up for monitoring.

❒ ***I am in the process of monitoring and assessing*** the student's health condition to determine a diagnosis and this assessment is likely to be completed by (*Please Note: Updated documentation will be required to continue to provide academic accommodations).*

❒ *Date of Next Clinical Assessment* _____/ _____/ _____ (Year, Month, Day), Interim accommodations may be provided during the assessment period. Updated documentation will be required to provide continued accommodation.

CLINICAL METHODS TO DIAGNOSE DISABILITY AND IDENTIFY FUNCTIONAL LIMITATIONS

How did you arrive at this diagnosis? Select all that apply:

- ❒ **Clinical Assessment.** (please provide a copy of the Assessment) Dates: _____
- ❒ **Diagnostic Imaging/ Tests.** Please indicate all that apply: ❍ MRI ❍ CT ❍ EEG ❍ X-Ray
- ❒ **Neuropsychological Assessment** (please provide a copy of the report which includes the list of tests completed and the scores)
- ❒ **Psychiatric Evaluation.** (please provide a copy of the evaluation) Dates: _____
- ❒ **Psycho-Educational Assessment** (please provide a copy of the evaluation report)
- ❒ **Behavioral Observations:** _____
- ❒ **Other:** _____

Functional Limitations: (Please describe)

_____

ACQUIRED BRAIN INJURY/CONCUSSION

Date of Acquired Brain Injury/Concussion: _____

Prior history of Acquired Brain Injury/Concussion? ❍ Yes ❍ No ❍ Unknown

Description of the current injury and its impact on functioning i.e., the ability to meet academic/placement and other related student obligations:

_____

_____

❒ **HEARING** Please attach a copy of the most recent audiogram. Symptoms are: ❒ Stable ❒ Progressive

	Left Ear	Right Ear
Hearing loss (specify type and severity)		
Tinnitus (please check)		
Other (please specify):		
Does the student's hearing fluctuate? Is so, please describe:		

❒ **VISION** Symptoms are: ❒ Stable ❒ Progressive

Dx: _____

	Visual Acuity	Visual Acuity – Best Corrected	Visual Field	Visual Field – Best Corrected
OD				
OS				
OU				

CURENT TREATMENT			
Treatment	**Start Date**	**Anticipated End Date**	**Frequency**
Chiropractic Therapy			
Massage Therapy			
Neuropsychological Assessment/Counseling			
Occupational Therapy			
Outpatient ABI Treatment Program			
Physiotherapy			
Psychotherapy			
Speech Language Therapy			
Other			

How long have you been treating the student? _____ First visit: _____ Last visit: _____

Do you monitor and or treat the student on a regular basis? ❍ Yes ❍ No

MEDICATION TREATMENT

Current Medications:

_____

Medication Side Effects: When are adverse or side-effects of any prescribed medication likely to negatively affect the student's academic functioning: _____

_____

Level of Impact (by medication) on Academic Functioning:

❍ Mild ❍ Moderate ❍ Severe ❍ N/A

Please list side effects of medication(s) which may impact academic functioning:

_____

_____

Headaches and Migraines

❒ Headaches	Triggers:
	Impact:
❒ Migraines	Triggers:

SEIZURES

Type of Seizure	Management *(e.g., rarely occurs; well controlled with medication; needs rest or break; always call 911)*
❒ Focal (partial seizures), with retained awareness	
❒ Focal (partial seizures) with loss of awareness	
❒ Absence seizures (petit mal)	
❒ Tonic-Clonic/convulsive seizures (grand mal)	
❒ Atonic seizures (drop attacks)	
❒ Clonic seizures	
❒ Tonic seizures	
❒ Myoclonic seizures	
❒ Psychogenic non-Epileptic seizures	

IMPORTANT NOTICE: As this certificate covers the impact of all types of disabilities, there are questions that may not be relevant to the student. Check **only** the areas that apply.

VISION	Mild	Moderate	Serious	Mild to Serious	Severe	Recommendations to manage impact/What alleviates Symptoms?
Eye fatigue/strain after _____minutes	❒	❒	❒	❒	❒	
Restricted ability to view screen and read academic material	❒ >1hr	❒ 30-60 mins.	❒ <15 mins.	❒	❒	
Other (specify): _____ _____	❒	❒	❒	❒	❒	
PHYSICAL	**Mild**	**Moderate**	**Serious**	**Mild to Serious**	**Severe**	**Recommendations to manage impact/What alleviates Symptoms?**
Ambulation ❒ Short Distance ❒ Other (e.g., uneven ground)	❒	❒	❒	❒	❒	
Standing (e.g., sustained standing in laboratory) ❒ No prolonged standing, specify mins. _____	❒	❒	❒	❒	❒	
Sitting for sustained period of time (e.g., in lecture /exam) ❒ No prolonged sitting, specify mins _____	❒	❒	❒	❒	❒	

PHYSICAL (Continued)	**Mild**	**Moderate**	**Serious**	**Mild to Serious**	**Severe**	**Recommendations to manage impact/What alleviates Symptoms?**
Stair Climbing ❒ None ❒ Other: _____	❒	❒	❒	❒	❒	
Lifting/Carrying/Reaching ❒ No lifting/carrying more than _____ lbs. ❒ Limited reaching/pushing/pulling ❒ Limited ROM (specify) ❒ Other: _____	❒	❒	❒	❒	❒	
Grasping/Gripping Dominance: ❒ Right ❒ Left ❒ Minimize repetitive use ❒ Limited dexterity (specify) _____	❒	❒	❒	❒	❒	
Neck ❒ No prolonged neck flexion ❒ Reduced ROM ❒ Other: _____	❒	❒	❒	❒	❒	
Pain ❒ Chronic ❒ Episodic	❒	❒	❒	❒	❒	
Skin ❒ Avoid contact with _____ ❒ Other: _____	❒	❒	❒	❒	❒	
Bowel and Urinary ❒ Frequent (which may impact academic activities such as writing an exam) ❒ Other: _____	❒	❒	❒	❒	❒	
Stamina ❒ Reduced stamina ❒ Frequency of rest breaks (e.g., minutes per hour) _____	❒	❒	❒	❒	❒	
SLEEP CYCLES & ENERGY	**Mild**	**Moderate**	**Serious**	**Mild to Serious**	**Severe**	**Recommendations to manage impact/What alleviates Symptoms?**
Fatigue ❒ Temporary due to medication side effects. Expected duration: _____ ❒ Fluctuating energy	❒	❒	❒	❒	❒	
Sleep Disorder or difficulties _____ _____	❒	❒	❒	❒	❒	**Note:** Students are encouraged to create healthy sleep habits and to discuss this with their health-care practitioner so as to minimize the impact at school.

COGNITIVE	**Mild**	**Moderate**	**Serious**	**Mild to Serious**	**Severe**	**Recommendations to manage impact/What alleviates Symptoms?**
Concentration difficulties	❒	❒	❒	❒	❒	
Difficulty with organization/time management	❒	❒	❒	❒	❒	
Low motivation	❒	❒	❒	❒	❒	

COGNITIVE (continued)	Mild	Moderate	Serious	Mild to Serious	Severe	Recommendations to manage impact/What alleviates Symptoms?
Executive functioning (ability to multitask, prioritize, organize and manage time)	❒	❒	❒	❒	❒	
Difficulty staying on and completing tasks	❒	❒	❒	❒	❒	
Judgement and insight	❒	❒	❒	❒	❒	
Difficulty with managing workload	❒	❒	❒	❒	❒	
Becomes overwhelmed	❒	❒	❒	❒	❒	
Need to ask for additional clarification and feedback on performance in lab/clinical/ placements/practicum/ related learning,	❒	❒	❒	❒	❒	
Other impacts and restrictions	❒	❒	❒	❒	❒	
PARTICIPATION/SOCIAL INTERACTION	**Mild**	**Moderate**	**Serious**	**Mild to Serious**	**Severe**	**Recommendations to manage impact/What alleviates Symptoms?**
Significant difficulty in social participation *(This may cause difficulties with participating in class and group settings)*	❒	❒	❒	❒	❒	
Significant difficulty related to speaking in public or presentations	❒	❒	❒	❒	❒	
Difficulty understanding common social cues *(e.g., do not pick up on metaphors, humor, facial expressions)*	❒	❒	❒	❒	❒	
Other impact and restrictions:	❒	❒	❒	❒	❒	

HEALTH & SAFETY	Comments
Difficulty operating machinery *(e.g. scientific or lab equipment, engineering machinery)*	❒ **MILD:** Should only operate with minimal supervision ❒ **MODERATE:** Should only operate with constant supervision ❒ **SEVERE:** Should never operate, with or without supervision
Difficulty handling dangerous or hazardous substances/chemicals	❒ **MILD:** Should only handle with minimal supervision ❒ **MODERATE:** Should only handle with constant supervision ❒ **SEVERE:** Should never handle, with or without supervision
Student has a physical health condition such that the university may need to respond in an emergency situation if symptoms of the condition appear while the student is on campus or during fieldwork. *(e.g., seizure disorder, severe allergic reaction)*	**If "Yes":** please describe condition(s) and recommended response. Comments**:**
Other: (please specify)	

This section to be completed by Regulated Health Care Practitioner

SUPPORTS RECOMMENDED BY THE HEALTH CARE PROVIDER FOR UNIVERSITY LEARNING

Please indicate the **RECOMMENTATIONS** you have regarding necessary and appropriate services, academic adjustments or other accommodations to equalize the student's educational opportunities at Xavier University of Louisiana. Please provide your specific recommendations (based upon your assessment, the student's clinical and academic history, and diagnosis). The Office of Disability Services will discuss these recommendations with the student to determine an appropriate accommodation plan. Please specify.

- ❒ Extended time for testing **1.5x**
- ❒ Extended time for testing **Double**
- ❒ Distraction reduced environment for testing
- ❒ Residential Accommodation(s) **(Specify below)**
- ❒ Emotional Support Animal (ESA)
- ❒ Other:

_____

_____

_____

_____

_____

_____

_____

_____

Health Practitioner's Signature:	**Date:**

Xavier University of Louisiana
Office of Disability Services
1 Drexel Drive – Box D **Office: (504)520-7315**
New Orleans, LA 70125 **Fax: (504)520-7943**

Authorization for Release of Health Information

Student's Information:

Student's Name: _____ XULA ID# _____

Home Address: _____

City/State/Zip Code: _____

The Office of Disability Services is required to keep information regarding your disability confidential, therefore this authorization is required to allow Xavier University of Louisiana Office of Disability Services (ODS) to share information regarding your disability with individuals and on-campus vendors who are considered to have a legitimate need to know in order to adequately provide for reasonable accommodations.

Such individuals /vendors may include the following:

- Xavier University of LA Professors and Staff members
- Sodexo Dining Services
- Residential Education
- Student Academic Success Office (SASO)
- Xavier University of LA Counseling Center
- Xavier University of LA Student Health Center
- Individual(s) designated by you: _____
  Name / Relationship

I hereby understand that by signing below, I authorize the Office of Disability Services (ODS) to disclose my accommodations each semester. This authorization is effective on the date signed below and continues until I revoke this authorization in writing, upon completion of my degree, or the end of this specific disability. Letters to revoke this authorization should be addressed to Xavier University of LA, Office of Disability Services, 1Drexel Dr., Box 180, New Orleans, LA. 70125.

Signature of Patient: _____Date: ____/_____/_____

Signature of Authorized Representative _____Date: ____/_____/_____

Relationship to patient _____