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Neurocognitive Disorder Verification Form

REQUEST FOR DISABILITY VERIFICATION OF A
NEUROCOGNITIVE DISORDER

Traumatic Brain Injury (TBI), Post Traumatic Stress
Disorder (PTSD), etc.

Form is to be completed by the student's evaluator and then returned to Accessibility Services.

To ensure the provision of reasonable and appropriate services for students with a neurocognitive disorder, the Accessibility Services office requires students to provide current and comprehensive documentation of their disability and its impact on their education. To standardize the gathering of such information, we ask that you complete the following and return to the address above. All material will be kept confidential.

Student Information

Student Name: _____

1. DSM-5 Diagnosis (ICD-10 Code) _____

2. Date of original diagnosis: _____

Please include any evidence of early impairment, whether or not the student received treatment:

3. Date of most recent evaluation _____

(documentation should be current, within the last 3-5 years; include update of the diagnosis if diagnostic report is older than 6 months)

4. Summary of symptoms and test findings which support the diagnosis, including any results from testing. Please include: 1) history of presenting symptoms; 2) duration, severity and prognosis of the disorder; and 3) relevant developmental, historical and familial data. Describe below and attach a list of test instruments and results; subtests should be included:

5. Describe any treatment plan(s) including a description of the student's responsibility.

6. Describe the student's current functional limitations in an educational setting:

7. Is this student currently on medication(s) that may affect their academic achievement?
If so, provide relevant information about their medical history:

8. Please provide your specific recommendations (based on your assessment, the student's clinical and academic history and diagnosis) for accommodations that you believe will help equalize the student's ability to access the Lewis-Clark State College's educational program.

Evaluator Information

I certify, by my signature below, that I conducted or formally supervised and/or co-signed the diagnostic assessment of the student named above and that I am a licensed psychologist, neuro-psychologist, psychiatrist, or other relevantly trained medical doctor or counseling professional.

Print Name: _____

Title: _____

Area of Specialty: _____

State License(s): _____

License Number(s): _____

Address: _____

Phone: _____ Fax: _____

e-mail: _____

Signature: _____ Date: _____

For Office Use Only

Accessibility Services Staff (Full Name): _____

Staff Signature: _____

Date Reviewed/Received: _____