# DOCUMENTATION OF ACQUIRED BRAIN INJURY
# FOR UC SANTA BARBARA

One of your patients has notified the Disabled Students Program (DSP) of your recent evaluation /diagnosis and treatment of his/her Acquired Brain Injury (ABI).

Students requesting services or accommodations at UCSB through the Disabled Students Program are required to provide current documentation. DSP requires comprehensive documentation in order to determine if the students' symptoms and their respective severity levels rise to the level of disability and if so, determine appropriate accommodations and academic support services. DSP eligibility is based upon documented medical and clinical data not simply self report or evidence of a diagnosis.

**Please complete the entire form. Eligibility cannot be determined without thorough information.**

All information that you provide will be shared with the student. This information is kept confidential, and cannot be released without written consent from the student.

| | |
|---|---|
| **Patient Name:** _____ | **7 Digit Perm #:** _____ |
| **Telephone #:** _____ | **Email:** _____ |

## I. Diagnosis and Evaluation

**What is the specific diagnosis?** _____

If known, when was the onset of ABI? _____

How did the ABI occur? _____

Please list specific assessments or evaluation procedures used to make the diagnosis. If applicable, please include all reports you performed in your evaluation along with this form.

| √ | Type of Assessment: | Date evaluated: |
|---|---|---|
| _____ | Clinical Interview with patient | _____ |
| _____ | Clinical Interview with parents, others | _____ |
| _____ | Neuropsychological evaluation | _____ |
| _____ | Psycho-educational evaluation | _____ |

Please list other types of evaluations and their respective dates.

When did you last evaluate this patient? _____

How often have you met with this patient? _____

Do you recommend further evaluations? If so, what evaluations do you recommend and when do you recommend those evaluations be completed?

What is the prognosis? Poor____ Guarded ____Fair ____Good ___Excellent____

## II. Treatment

Is the patient currently in treatment with you? Yes____ No____

When was the last appointment date? _____

If applicable, does medication mitigate the patient's symptoms?
Completely Mitigated_____ Partially Mitigated _____ Not Mitigated_____

Provide a list of medication(s), dosage, and side effects.

When were medications prescribed?_____

If applicable, do other treatments mitigate the patient's symptoms?
Completely Mitigated_____ Partially Mitigated _____ Not Mitigated_____

Please list those treatments.

## III. Symptoms and Severity

**Overall Level of ABI Severity:**

Please indicate overall level of ABI severity *(moderate to severe rating indicates substantial limitation in one or more major life activities; please place an **X** at the most appropriate level).*

**0----------50----------100**
**Mild Moderate Severe**

**Specific ABI Symptoms and Severity Levels:**
Please indicate which specific symptoms *substantially* impact one or more life functions. Please check the appropriate spaces to indicate:

- The level of severity (1 = moderate, 3 = severe)
- Whether or not the symptoms are temporary or permanent:

| **Symptoms** | **Level of Significance** | | | **Temporary** | | **Permanent** | |
|---|---|---|---|---|---|---|---|
| | **1** | **2** | **3** | **Y/N** | **How long?** | **Yes** | **No** |
| **Inattention** | | | | | | | |
| Difficulty with attention to detail | | | | | | | |
| Difficulty sustaining attention | | | | | | | |
| **Distractibility** | | | | | | | |
| Distracted by thoughts | | | | | | | |
| Distracted by external stimuli | | | | | | | |
| **Hyperactivity/Impulsivity** | | | | | | | |
| Fidgety/restless | | | | | | | |
| Irritable | | | | | | | |
| Impulsive | | | | | | | |
| **Executive Functioning** | | | | | | | |
| Poor short term memory | | | | | | | |
| Poor time management under pressure | | | | | | | |
| Loses necessary items | | | | | | | |
| Difficulty starting tasks | | | | | | | |
| Difficulty organizing time/tasks | | | | | | | |
| Difficulty establishing routines | | | | | | | |
| Poor follow through | | | | | | | |
| **Affect** | | | | | | | |
| Depressed mood over difficulties with ABI | | | | | | | |
| Anxious about school performance | | | | | | | |
| Fatigue | | | | | | | |
| Difficulties regulating emotions | | | | | | | |
| **Sensory** | | | | | | | |
| Difficulty interpreting touch, temperature, movement, limb position, and fine discrimination | | | | | | | |
| **Speech and Language** | | | | | | | |
| Difficulty understanding speech | | | | | | | |
| Difficulty speaking and being understood | | | | | | | |

| **Symptoms** | **Level of Significance** | | | **Temporary** | | **Permanent** | |
|---|---|---|---|---|---|---|---|
| **Speech and Language (continued)** | **1** | **2** | **3** | **Y/N** | **How long?** | **Yes** | **No** |
| Slurred Speech | | | | | | | |
| Speaking very fast or very slow | | | | | | | |
| Problems reading | | | | | | | |
| Problems writing | | | | | | | |
| **Vision** | | | | | | | |
| Partial or total loss of vision | | | | | | | |
| Weakness in eye muscles and double vision | | | | | | | |
| Blurred vision | | | | | | | |
| Problems with judging distance | | | | | | | |
| Involuntary eye movements | | | | | | | |
| Intolerance of light | | | | | | | |
| **Hearing** | | | | | | | |
| Decrease or loss of hearing | | | | | | | |
| Ringing in the ears | | | | | | | |
| Increased sensitivity to sounds | | | | | | | |
| **Loss or diminished sense of smell** | | | | | | | |
| **Loss or diminished sense of taste** | | | | | | | |
| **Seizures:** If yes, how often?_____ | | | | | | | |
| **Physical Changes** | | | | | | | |
| Physical paralysis | | | | | | | |
| Chronic pain | | | | | | | |
| Control of bowel and bladder | | | | | | | |
| Difficulties falling asleep | | | | | | | |
| Difficulties staying awake | | | | | | | |
| Loss of stamina | | | | | | | |
| Appetite changes | | | | | | | |
| Regulation of body temperature | | | | | | | |
| Muscle spasms, stiffness | | | | | | | |
| **Additional Symptoms** | | | | | | | |
| | | | | | | | |
| | | | | | | | |

## IV. Additional Information

Please provide any additional information. How the patient's disability symptoms impact him/her in various academic tasks (e.g., exam taking, focus in lectures, time management and organization, completion of long term projects)?

Signature of
Diagnosing Professional_____Date_____

Please Print Name_____
License/Certification Number:_____
Phone Number:_____ Fax Number: _____

Documentation is incomplete without signature of diagnosing professional. Please send form to DSP at (805) 893-7127 FAX, or mail it to: University of California, Disabled Students Program, 2120 Student Resource Building, Santa Barbara, CA 93106-3070. Please call (805) 893-2668 if you have any questions or concerns.