Office for Disability Services - Lincoln College
Diagnosing Professional Form

A patient/client of yours has requested disability-related services from the Office for Disability Services at Lincoln College (ODS). As this student's treating specialist, you are asked to provide the following information to allow the College to consider this student's service request(s). ***Information you provide will be kept in the student's ODS file and is considered by law to be protected by the Family Educational Rights and Privacy Act. As such, the student has a legal right to view the document.***

1. **Patient/Client Name:**

2. **The Condition of Patient/Client:**
   A. What is the diagnosis/impairment? _____
   B. When the diagnosis was originally made? _____
   C. Is the patient/student currently under your care? _____
   D. When did you last see the patient/student? _____
   E. Is the impairment temporary (< 3months) or persistent? _____
   F. Please identify factors that may affect the severity of the impairment (e.g., to what degree might the impairment be *minimized* by medications, hearing aids, etc.?) Alternatively, could there be an adverse effect (e.g., medication side effects)?
   G. Are the functional limitations current (affecting the student now) or potential (student has been affected in the past and/or may be in the future)? Please explain.

3. **Please complete the following functional impact assessment.**

LIMITATION IS: **1 =Unable to Determine** **2 = Mild** **3 = Substantial**

1	2	3	Major Life Activity		1	2	3	Learning
			Caring for oneself					Reading
			Talking					Writing
			Hearing					Spelling
			Breathing					Calculating
			Seeing					Concentrating
			Walking/Standing					Memorizing
			Lifting/Carrying					Listening
			Sitting					Communicating
			Performing Manual Tasks					Other (please list)
			Eating					
			Working					
			Interacting with Others					
			Sleeping					
			Thinking					
			Major Bodily Functions					

4. **What method(s) were used to assess functional limitation? Please list or attach under separate cover.**

5. **Please list or attach your recommendations for accommodations within the academic environment. Please provide a rationale for any recommendation made utilizing data from objective measures, the educational record, or other data sources.**

6. Certifier Information:

- Name _____
- Specialty_____
- License _____
- Address _____
- Phone _____
- E-mail _____
- Signature _____
- Date _____