



## **Documentation Guidelines for Chronic Medical/Health Disabilities**

These guidelines apply to students who have chronic disabilities in the following areas:

- **Mobility** – such as use of wheelchair, crutches, or cane, or impaired hand coordination
- **Systemic** – includes chronic illnesses or conditions such as diabetes and epilepsy
- **Acquired Brain Injury** – affecting processing speed, memory, communication, motor, sensory, physical, and/or psychosocial abilities

Students requesting accommodations for a disability listed above are asked to submit documentation that meets the guidelines listed below. In addition, individuals with acquired brain injury may need to submit a psycho-educational test battery, as referenced in the documentation guidelines for learning disabilities.

- 1) **A Qualified Evaluator.** Professionals conducting assessments, rendering a medical diagnosis, and making recommendations for appropriate accommodations must be qualified to do so. These are physicians, including licensed M.D.'s and D.O.'s. Documentation must meet the following criteria:
  - include the name, title, and professional credentials of the evaluator
  - be presented on the professional's letterhead, typed, dated, signed, and legible and
  - the evaluator may not be a family member
- 2) **Current Documentation.** Reasonable accommodations are based on the current impact of a disability. Therefore, it is critical that medical documentation describe an individual's current level of functioning and need for accommodations. A full report from a treating healthcare professional completed within the past twelve months is considered current, unless the condition is permanent/unchanging. The documentation may need to be updated annually so that we can best accommodate the student.
- 3) **Comprehensive Documentation.** Medical disabilities encompass a myriad of conditions. In addition, medical conditions are often changeable in nature, and sometimes difficult to categorize. Documentation must therefore be thorough,

Disability Support Services — 2609 Midwestern Pkwy, Wichita Falls, TX 76308

Phone: 940-397-4140 — Fax: 940-397-4180

Email: [disabilityservices@msutexas.edu](mailto:disabilityservices@msutexas.edu)

giving a full picture of the individual, not simply a diagnosis. A diagnosis alone is not a basis for accommodation. Documentation must include:

- A discussion of:
  - a history of presenting symptoms and relevant medical history
  - description of current impairment
  - a summary of assessment procedures and evaluation instruments/reports used
  - diagnosis duration and severity of the disorder
  - treatment and medication history, including medication side effects
  - if applicable, documentation of assistive device and technology used, with estimated effectiveness; this would include a history of any disability-related accommodation(s)
  - status of the individual's condition – static, improving, or degrading
  - expected progression of the condition over time
- A **clear** diagnosis of medical disability must be rendered including:
  - **clear statement of** diagnosis, the subtype if applicable, with *ICD-10* code
  - the diagnostic criteria on which the diagnosis is based
  - **CANNOT INCLUDE** wording such as “seems to indicate” or “suggests”
- The current functional limitations – the ways that the diagnosed disability substantially limits the student in major life activity – of the individual in an academic environment
- Appropriate and specific recommendations for accommodation in an academic environment, accompanied by clear rationale supported by interview, observation, and/or testing

4) **Supporting Documentation.** The qualified physician's report, while necessary, is by no means the only documentation we can use to better understand and accommodate the student with a chronic medical/health disability. Other helpful documents include: records of previous accommodation, high school 504 plans or IEP's, previous medical evaluations, report cards, transcripts, and parent, teacher, tutor, or employer reports. Disability Support Services (DSS) reserves the right to access student transcripts (e.g. classes taken and grades earned at MSU Texas) for evaluation purposes.

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