Traumatic Brain Injury/Brain Insult
(Trauma to the brain resulting from injury, cerebral vascular accidents, tumors, or other medical conditions)

Documentation Requirements

EVALUATION BY AN APPROPRIATE EXPERT
Students requesting accommodations on the basis of a traumatic brain injury (TBI) or brain insult are requested to provide documentation by a neuropsychologist.

DOCUMENTATION MUST BE CURRENT
Generally, documentation must be no more than 3 years old for a high school student and no more than 5 years old for an adult. A school plan such as an IEP or 504 Accommodation Plan is insufficient documentation. All testing instruments must be standardized for use on adults.

DOCUMENTATION MUST INCLUDE, BUT IS NOT LIMITED TO, THE FOLLOWING ELEMENTS:

1. A THOROUGH NEUROPSYCHOLOGICAL EVALUATION
   The assessment must address the areas of attention, visuoperception/visual reasoning, language, academic skills, memory/learning, executive function, sensory, motor and emotional status. Data should include standard scores and percentiles.

2. EVIDENCE OF CURRENT IMPAIRMENT
   Documentation should discuss history of the individual’s presenting symptoms and evidence of behaviors that significantly impair functioning.

3. DIAGNOSTIC INTERVIEW
   Must contain self-report and third-party information pertaining to:
   a. developmental history
   b. family history
   c. learning or psychological difficulties
   d. relevant medical history
   e. a thorough academic history

4. EVIDENCE THAT ALTERNATIVE DIAGNOSES/EXPLANATIONS WERE RULED OUT
   The documentation must investigate and discuss the possibility of dual diagnoses and alternative or coexisting mood, learning, behavioral, and/or personality disorders that may confound the diagnosis. Records of academic progress prior to the onset of TBI must be reviewed to substantiate that the current level of functioning is a direct cause of the brain injury (i.e., that function has changed as a result of the injury).
5. DIAGNOSIS

Include a specific statement of diagnosis, as well as the corresponding DSM-V code.

6. CLINICAL SUMMARY

Must address:

a. The substantial limitations to major life activities posed by the disability.

b. A description of the extent to which these limitations would impact the academic context for which accommodations are being requested.

c. Suggestions as to how the specific effects of the disability may be accommodated.

d. The rationale behind the suggested accommodations. Any recommendation for an accommodation should be based on objective evidence of a substantial limitation to learning, supported by specific test results and clinical observations. In establishing the rationale for recommended accommodations, test data should be used to document the need.

7. ADDITIONAL REQUIREMENTS

a. Interpretation of test results is required. Test protocol sheets, handwritten summary sheets or scores alone are not sufficient.

b. All reports must be in narrative form, typed, signed by the diagnosing clinician, and must include the names, titles and professional credentials of the evaluators as well as the date(s) of testing. Documentation must be submitted on the official letterhead of the professional diagnosing the disability.