



KOKUA Program
 Office for Students with Disabilities
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 Honolulu, Hawaii 96822

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**Verification of a Health &/or
 Mobility-related Disability**

Your patient, _____ (DOB: _____) has requested support services through the University of Hawai'i KOKUA Program (program for students with disabilities). In order to provide appropriate services we require additional information from you. Please respond to the following questions:

1. What is the patient's diagnosis?

2. What were the assessment or evaluation procedures used to make the diagnosis?

3. What historic data was taken into account in making the diagnosis?

4. Please indicate the major symptoms of the disorder currently manifested by the student, including level of severity:

SYMPTOM	LEVEL OF SEVERITY				
	Mild	Moderate			Severe
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5

5. What medications are currently prescribed? Are there any side effects, and if so, how severe?

6. Is the individual currently in treatment with you, and if so, when did you last see him/her?

7. What is the prognosis?

8. What recommendations do you have regarding accommodations (i.e. extra time for exams, notetaker, adaptive equipment) in the university setting? Please describe your rationale for the accommodations you have recommended.

Thank you for your cooperation. You can mail or FAX your report to us at (808) 956-8093. Please call us at (808) 956-7511 if you require additional information. Please attach any reports.

Name of Physician/Clinician _____ License Number _____

Signature _____ Date _____

Telephone _____ Address _____

Sincerely Yours,

KOKUA Counselor