Dear Student,

The Office of Residential Programs offers a variety of living environments that accommodate many different lifestyle needs. Within this assortment of provisions, there are a limited number of medical single rooms available for students with severe medical, psychological, psychiatric, mobility, or visual or hearing impairment related conditions, whereby the symptoms of such conditions prohibit the student from living with a roommate.

Students who feel that they may have such a condition may request an Accommodation of a Single room evaluation with Disability Support Services. They must meet with a counselor at Disability Support Services and submit updated documentation (form enclosed) from your treating practitioner in order to request an Accommodation of a Single room.

MEDICAL SINGLE ROOM PLACEMENT APPLICATION:

A recommendation from DSS for the Accommodation of a Single room is subject to renewal each semester as needed.

In order to be considered for this accommodation your condition must comply with the above requirement. You may be asked for updated medical and/or psychological/psychiatric documentation from your treating provider.

Documentation must include all of the following:

1. Diagnosis of Condition
2. Nature of related symptoms, Severity of symptoms
3. Length of time you have been symptomatic
4. How your symptoms functionally prevent you from living with a roommate
5. Medications
6. History of related hospitalizations if applicable
7. A specific recommendation that it is your clinician’s professional opinion that an accommodation of a single room placement is essential for your health/mental health; even though this may increase isolation.
8. Verification from the practitioner of ongoing treatment for your disability (dependent upon diagnosis)

The Disability Support Services Counselor will review your documentation to determine whether you are eligible to receive a Single Room Accommodation recommendation. Please be sure to include your contact information on the documentation form so that DSS may contact you to discuss your request when it is reviewed for eligibility.
If you are eligible, a recommendation will be made to the Associate Director of Residential Programs. The Associate Director of Residential Programs is not advised of your diagnosis. Information about the diagnosis and treatment of your condition remains confidential. It is entirely your choice to share or not share this information.

As we honor your right to privacy, we also appreciate that on occasion, medical and/or psychiatric conditions can present times of vulnerability when support would be helpful to you. Here are some campus resources that you may choose to contact:

Disability Support Services: 631 632-6748
Counseling and Psychological Services: 631 632-6720
Suicide Prevention: 631 632-9666
Center For Prevention and Outreach: 631 632-2748 (2-CR4U)
Alcohol/Drug Prevention: 631 632-6729
Sexual assault: 631 632-9666
Health Education: 631 632-6682
Student Health Service: 631 632-6740
University Police/Ambulance: 631 632-3333 (24 hr./day, 7 days/week)
Safe Ride: 631 632-RIDE
Walk Service: 631 632-6337
Department of Residential Programs: 631 632-6750
Campus Ombuds Office: 631 632-9200

OFF CAMPUS RESOURCES:

RESPONSE Hotline: 631 751-7500 (24 hrs./day, 7 days/week)
Victim’s Information Bureau Hotline: 631 360-3606 (24 hrs./day, 7 days/week)
Stony Brook University Hospital (General Information): 631 689-8333 (24 hrs./day, 7 days/week)
Stony Brook University Hospital Emergency Department: 631 444-2465 (24 hrs./day, 7 days/week)

Wishing you a fantastic Stony Brook University experience!
Medical Single Documentation Form

Student’s Name: _______________________________ Student DOB: _______________________________

SBID# _______________________________ Telephone _______________________________

Stony Brook University complies with federal and state disability laws that prohibit discrimination and require that universities ensure equal access for qualified persons with disabilities to educational programs, services, and activities. Please complete the form below to assist DSS in determining appropriate and reasonable disability accommodations. With regard to specific housing as a disability accommodation, there are a limited number of single room residences. We make our best effort to ensure that students with the most significant disabilities have priority placement so that they can actively participate in educational programs and activities. Additional documentation may be required.

To be completed by the student’s treating physician, NOT by a family member. All items are required. Please print legibly.

Complete Diagnosis: _______________________________

Date of Diagnosis: _______________________________

Date of last visit for this condition: _______________________________

Procedures/assessments used to diagnose this student’s condition (ATTACH COPIES of assessment results used in making/confirming diagnosis): _______________________________

Severity of the condition: _______________________________

Mild Moderate Severe

Student is compliant with medical treatment for this condition: _______________________________

Rarely Sometimes Often Unknown

Does this student take prescription medication for this condition? Yes No If yes, which medications? Please note any side effects: _______________________________

Epi-Pen? Yes No

Nature of symptoms/ limitations _______________________________

With what frequency does this student experience the above limitation(s)? _______________________________

Rarely Occasionally Frequently

Has this student received in-patient treatment for this condition within the last year? Yes No

Explain how symptoms functionally prohibit student from living with a roommate: _______________________________

Your specific recommendation that it is your professional opinion that an accommodation of a single room placement is essential for the student’s physical/mental health; even though this may increase isolation: _______________________________

Describe your follow-up plan for your patient: _______________________________

Do you recommend academic accommodations? (must be clearly linked to functional limitations): _______________________________

Provider’s Signature: _______________________________

Provider’s Name: _______________________________

Address: _______________________________

License/Cert#: _______________________________ State: _______________________________

Specialty: _______________________________

Phone: _______________________________ Fax: _______________________________

Email: _______________________________

Affix Stamp or Business Card Here