Disability Verification Form

Psychological/Psychiatric Disabilities

To be completed by a qualified professional

A student under your care has requested accommodations for a disability under Section 504 of the Rehabilitation Act of 1973, title II of the Americans with Disability Act (ADA) of 1990

1. Name of Student:_____ DOB:_____

2. Evaluator

The professional submitting the documentation must be qualified to conduct the assessment and make a diagnosis. The professional must trained in differential diagnosis and in assessing the full range of psychiatric disorders (e.g. licensed clinical psychologist, neuropsychologist, psychiatrist or other medical specialty). The professional may not be related to the student.

Name (Printed):		Date:
Degree:		Medical Specialty:
License Number:		State of Issue:
Address:		
Phone:	Fax:	Email:
Signature:		

3. Documentation must be current. Supporting documentation cannot be more than one (1) year old.

4. Clinical Assessment

a.

Date Student First Seen:	Date Student Last Seen:
Do you see this student regularly:	If so, how often:
Date of Diagnosis:	

b. Multi-axial DSM-V diagnosis:

AXIS I:_____

AXIS II:_____

AXIS III:_____

AXIS IV:_____

AXIS V:_____

c. Which of the following was used in your clinical assessment?

____ Interview
____ Developmental history
____ Relevant family history, including learning, attentional, physical and psychological issues
____ Relevant medical history, including medications
____ Psychosocial history, including interventions
____ Educational history, including K-12 and post-secondary
____ History of prior therapy
____ Psychoeducational reports (dates)_____
____ Employment history
____ Rating scales

d. Relevant testing. Please list any psychoeducational or neuropsychological tests performed to evaluate the student's ability to perform in academic settings. Copies of the assessments should be included as part of the

e.. Discuss alternative diagnoses that were ruled out. Give a detailed explanation for the exclusion(s).

_____

_____

_____

_____

f. Give a detailed outline of the student's current treatment plan, including medications, coaching, development of learning strategies, etc. If medication is part of the treatment plan, please list the medication, dosage, frequency of use and possible side effects. How often is the efficacy of the treatment plan assessed? If the student is responding positively, to what extent does the treatment plan alleviate the need for accommodations within the academic setting? Attach additional sheets if necessary.

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g. Is the student stable at this time?_____

h. Does the student experience crisis episodes? If so, what is the appropriate manner in which they should be handled?

_____

_____

_____

i. Please list the specific academic accommodations you recommend for this student, and a rationale for the basis of the recommendation(s).

Accommodation Recommended	**Rationale**

j. Will the student's disorder require absences from class? ____ Yes ____ No
If yes, please indicate the reason. *

Due to symptoms experienced

As a result of side effects of medication or treatment

For treatment of the disorder

*Please note -