Document**ation requirements for Psychiatric Disabilities**

Student Accessibility Services provides academic accommodations and services to students with Psychiatric Disabilities. Students seeking accommodations must provide relevant and comprehensive documentation of their disability so that the office of Student Accessibility Services can determine the student’s eligibility for accommodations.

**Documentation should include:**

1) A completed disability verification form (pages 2-4 of this document).

OR

1) A relevant and comprehensive adult normed psychoeducational or neuropsychological evaluation. To include; clear statement of disability including diagnosis, test scores, clinical assessment of procedures and evaluators narrative.

All documentation is considered confidential and can be mailed or faxed to:
Student Accessibility Services
Assumption College
500 Salisbury Street
Worcester, MA 01609
Fax: (508)767-7139
Phone: (508)767-7500
Disability Verification Form - Psychiatric Disability (to be completed by appropriate practitioner)

This form is intended to assist your patient in meeting the documentation requirements for requesting academic accommodations on the basis of a Psychiatric Disorder at Assumption College. Please fill out all of the questions on the form below.

All information is considered confidential. Please feel free to contact Student Accessibility Services with any questions.

Student/Patient Name: ____________________________________________

1. Please list all DSM-IV or ICD Diagnoses (text and code):
   AXIS I: 
   AXIS II: 
   AXIS III: 
   AXIS IV: 
   AXIS V
   Severity of disorder (current GAF Score) _____________________
   a. Date diagnosed: __________________
   b. Date of your last clinical contact with student: ____________

2. Evaluation
   a. How did you arrive at this diagnosis? Please check all relevant items below, adding brief notes that you think might be helpful to us as we determine eligibility for accommodations.
      □ Structured or unstructured interviews with student
      □ Interviews with other persons (i.e. parent, teacher, therapist)
      □ Behavioral observations
      □ Neuropsychological testing. Attach documentation
      □ Psychoeducational testing. Attach documentation
      □ Other (Please specify) _____________________________________________________________
   b. Date of last evaluation ____________________________________________________________
   c. Corroboration of history of childhood onset? Y □ N □
      By whom? ________________________________________________________________

3. Functional Limitations Y □ N □ If yes, please describe: ____________________________________________________________
   ______________________________________________________________________________
a. Please describe in detail any functional limitations that fall into the significant range.

__________________________________________________________________________________________________
__________________________________________________________________________________________________

b. Please list current medications and treatment history.

__________________________________________________________________________________________________
__________________________________________________________________________________________________

c. Special considerations, e.g. medication side effects:

__________________________________________________________________________________________________
__________________________________________________________________________________________________

4. Coexisting Conditions
Please provide details about any coexisting psychiatric or medical conditions.

__________________________________________________________________________________________________

5. Past Accommodations
Please mark whether student has utilized accommodations in the past. Y □  N □
Please describe:

__________________________________________________________________________________________________
__________________________________________________________________________________________________

6. Suggested Accommodations
Please list the specific academic accommodations you suggest based on your assessment of the student’s clinical and academic history and diagnosis.

__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

7. (Optional) Please provide any additional information you feel will be useful in determining the nature and severity of the student’s disability, and any additional recommendation that may assist in determining appropriate accommodations and interventions.

__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

Thank you for your help in providing this information so that we may begin services as soon as possible. Please complete the provider information below. This form should be signed and returned to Student Accessibility Services at Assumption College, 500 Salisbury Street, Worcester, MA 01609 or by fax to (508)767-7139.
Provider information

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

Signature:___________________________________ Date:____________________

Print name and Title: _____________________________________________________

State of License: _______ License Number: ______________________________

Address: ______________________________________________

Phone: _____________________________ Fax: ______________________

Please return this signed disability verification form:

Student Accessibility Services
Assumption College
500 Salisbury Street
Worcester, MA 01609
Phone: (508)767-7139
Fax: (508)767-7500