PSYCHIATRIC DISABILITY VERIFICATION FORM

Students who are seeking assistance from the Office of Accessibility/Academic Enrichment Center must submit documentation to verify the diagnosis of a disability. The purpose of the documentation is to determine eligibility for academic accommodation(s). Eligibility to receive accommodations under Section 504 of the 1973 Rehabilitation Act and the Americans with Disabilities Act of 1990 is based upon the existence of a disorder that currently substantially limits one or more major life activities such as walking, seeing, hearing, speaking, breathing, learning, working or taking care of oneself. This form assures that appropriate diagnostic measures have been taken to verify eligibility and adequately support any request for disability services and/or reasonable academic accommodations.

STUDENT INFORMATION
(Please print legibly or type)

Name (Last, First, Middle): ____ Date of Birth: ___/___/___

Student Status (check one): ☐ Current ☐ Transfer ☐ Prospective Last 4 Digits SSN: _________

Local phone: (___) ____-_____ Cell phone: (___) ____ -_____ Email: __________________@___________

Address: ______________________________ _____________ ______ _______
(Street) (City) (State) (Zip)

DIAGNOSTIC INFORMATION TO BE COMPLETED BY DIAGNOSTICIAN
(Please print legibly or type)

Date of Diagnosis: ____/____/____ **Date student was last seen: ____/____/____**

DSM IV Diagnosis

Axis I: ____

Axis II: ____

Axis III: ____

Axis IV: ____

Axis V (GAF Score): ____

PYSICIAN NOTES: ____
____
____

DIAGNOSTIC INFORMATION (Con't)

(Please print legibly or type)

What other tools we used to arrive at your diagnosis?

- ☐ Structured or unstructured interviews with the student
- ☐ Interviews with other persons
- ☐ Behavioral observations
- ☐ Developmental history
- ☐ Educational history
- ☐ Medical history
- ☐ Neuropsychological testing Date(s) of testing? ____
- ☐ Psycho-educational testing Date(s) of testing? ____
- ☐ Standardized or non-standardized rating scales
- ☐ Other (Please specify)____

What is the severity of the disorder? ☐ Mild ☐ Moderate ☐ Severe

Please describe: ____

____

____

____

What is the expected duration of this disability: ☐ Temporary ☐ Permanent ☐ Unknown

Major Life Activities Assessment

Please check which of the following major life activities listed above that are affected because of the impairment. Indicate severity of limitations.

Life Activity	Negligible	Moderate	Substantial	Unknown
Concentration	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Eating	☐	☐	☐	☐
Social Interactions	☐	☐	☐	☐
Self Care	☐	☐	☐	☐
Regular Attendance	☐	☐	☐	☐
Keeping Appointments	☐	☐	☐	☐
Stress Management	☐	☐	☐	☐
Managing internal distractions	☐	☐	☐	☐
Managing external distractions	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐
Organization	☐	☐	☐	☐

Please address specific symptoms and how each might affect the student's academic performance?

Symptom: ________________________ Affect: ________________________
Symptom: ________________________ Affect: ________________________
Symptom: ________________________ Affect: ________________________
Symptom: ________________________ Affect: ________________________
Symptom: ________________________ Affect: ________________________
Symptom: ________________________ Affect: ________________________

Describe situations or environmental conditions that might exacerbate of the condition. ____________

____
____
____
____

Is this student currently receiving therapy or counseling? □ Yes □ No
Frequency: □ Weekly □ Monthly □ Other ________________________

List current medication(s), impact, and adverse side effects

Medication: ________________ Impact: ________________________
Side effects experienced by patient: ________________________
Medication: ________________ Impact: ________________________
Side effects experienced by patient: ________________________
Medication: ________________ Impact: ________________________
Side effects experienced by patient: ________________________
Medication: ________________ Impact: ________________________
Side effects experienced by patient: ________________________
Medication: ________________ Impact: ________________________
Side effects experienced by patient: ________________________
Medication: ________________ Impact: ________________________
Side effects experienced by patient: ________________________
Medication: ________________ Impact: ________________________
Side effects experienced by patient: ________________________
Medication: ________________ Impact: ________________________
Side effects experienced by patient: ________________________

Academic Accommodations Recommended

Please state specific recommendations regarding academic accommodations for this student, and a rationale as to why these accommodations/adjustments/services are warranted based upon the student's functional limitations.

□ Adaptive Technology **Rationale**: ________________________
□ Electronic Text **Rationale**: ________________________
□ Note-taking **Rationale**: ________________________
□ Para Transit **Rationale**: ________________________
□Testing Accommodations **Rationale**: ________________________
□ Other: ____________ **Rationale**: ________________________

If the current treatments (i.e. medications and therapy) are successful, state the reasons the above academic adjustments, auxiliary aids, and/or services are necessary. ________________________

____

PROVIDER INFORMATION
(Please print legibly or type)

Provider Name (Print): ____________________________________ Title: ____________________________

Date: ___/___/___ Provider Signature: ____

License/Certification Number: ______________________________________ Phone Number: (____) ____-_____

Address: _____________________________ _____________ ______ _______ Fax Number: (____) ____-______
(Street) (City) (State) (Zip)

Please return the completed form to:

Office of Accessibility
The University of Toledo
1625 W. Rocket Dr. Mailstop 342
Toledo, OH 43606
ATTN: ______________________

Academic Enrichment Center
The University of Toledo Health Science Campus
Mulford Library Building Rms 506/507 Mailstop 1046
Toledo, OH 43614
ATTN: ____________________

NOTE: If neuropsychological and/or psycho-educational assessments are available please attach and submit with form.