Accommodation Services Office

DOCUMENTATION OF PSYCHOLOGICAL DISORDER

The Accommodation Services Office provides services to students with diagnosed psychological disabilities. To determine eligibility for services, this office requires **current comprehensive documentation** of this disorder from a qualified diagnosing **psychologist, psychiatrist, neurologist or other licensed mental health professional <u>currently</u> treating the student.**

If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be substituted as documentation instead of this form.

Please Print Legibly

Student Name: _____

Date Completed: _____/_____/_____ Student's Date of Birth _____/_____/_____

1. DSM-5 diagnosis: _____

2. Date of diagnosis: _____/_____/_____

   First contact with student _____/_____/_____ Last contact with student: _____/_____/_____

3. In addition to DSM 5 criteria, how did you arrive at your diagnosis?

   - ☐ Structured or unstructured clinical interviews with the individual
   - ☐ Interviews with other individuals
   - ☐ Behavioral observations
   - ☐ Developmental history
   - ☐ Educational history
   - ☐ Medical history
   - ☐ Neuro-psychological testing – Date: _____
   - ☐ Psycho-educational testing – Date: _____
   - ☐ Standardized or non-standardized rating scales
   - ☐ Other (please specify): _____

4. What is the severity of the disability? Please check one:

   ☐ Mild ☐ Moderate ☐ Severe

   Explain Severity: _____

5. What is the expected duration of this disability? _____

_____

6. Please list and describe the major life activities/functional limitations that are significantly impacted by the disability and degree of severity. ***Please note, if major life activities are not significantly impacted, no accommodations may be considered.***

_____

_____

_____

_____

_____

_____

7. Is the student currently receiving therapy/counseling? Yes ☐ No ☐

8. Does the student plan to continue therapy/counseling with you over the course of the semester?

_____

_____

9. List current medications that may impact the student in the educational setting, and what impact they may have.

_____

_____

_____

10. Describe any situation or environmental conditions that might lead to an exacerbation of the condition.

_____

_____

_____

11. State specific recommendations regarding academic accommodations for this student, and the rationale as to why these accommodations/services are warranted based upon the student's functional limitations. Indicate why the accommodations are necessary.

_____

_____

_____

_____

_____

_____

12. If any co-morbid conditions exist, please describe.

_____

_____

Provider Information

Name (Please Print):		
Medical Specialty:	**License #:**	
Address:		
Phone:	**Email:**	
Signature:		**Date:**

Please mail or fax this completed form and any additional information to:

Accommodation Services Office
Lakeshore Technical College
1290 North Avenue
Cleveland, WI 53015

Phone: (920) 693-1222 or (920) 693-1274
Fax: (920) 693-1827