Psychiatric Disability Verification Form

The Learning Support and Disability Services Department at The College of Idaho provides academic services and accommodations for students with diagnosed disabilities. The documentation provided regarding the disability diagnosis must demonstrate a disability covered under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990. The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities. In addition, in order for a student to be considered eligible to receive academic accommodations, the documentation must show functional limitations that impact the individual in the academic setting.

The LSDS Department requires current (no more than three years old) and comprehensive documentation in order to determine appropriate services and accommodations. The outline below has been developed to assist the student in working with the treating or diagnosing healthcare professional(s) in obtaining the specific information necessary to evaluate eligibility for academic accommodations.

A. The healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so. These persons are generally trained, certified or licensed psychologists or members of a medical specialty.

B. All parts of the form must be completed as thoroughly as possible. Inadequate information, incomplete answers and/or illegible handwriting will delay the eligibility review process by necessitating follow up contact for clarification.

C. The healthcare provider should attach any reports which provide additional related information (e.g. psycho-educational testing, neuropsychological test results, etc.). If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted for documentation instead of this form**.** ***Please do not provide case notes or rating scales without a narrative that explains the results.***

D. After completing this form, sign it, complete the Healthcare Provider Information section on the last page and mail or fax it to us at the address/numbers provided. The information you provide will *not* become part of the student's educational records, but it will be kept in the student's file at LSDS, where it will be held strictly confidential. This form may be released to the student at his/her request. In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment.

If you have questions regarding this form, please call the LSDS Department at (208) 459-5141 or email tkazan@collegeofidaho.edu. The LSDS Department fax number is (208) 459-5108. Thank you for your assistance.

STUDENT INFORMATION
(Please Print Legibly or Type)

Name (Last, First, Middle):
_____

Date of Birth: _____ **Last 4 Digits of SSN: _____**

Status (check one): ☐ **current student** ☐ **transfer student** ☐ **prospective student**

Local phone: (_____) _____-_____ **Cell phone: (_____) _____-_____**

Address (street, city, state and zip code):

_____

_____

C of I E-Mail address:_____@yotes.collegeofidaho.edu

Other E-mail address:_____

DIAGNOSTIC INFORMATION
(Please Print Legibly or Type)

1. Date of Diagnosis: _____
2. Date student was last seen: _____
3. DSM-IV Diagnosis

   Axis I:_____

   Axis II:_____

   Axis III:_____

   Axis IV:_____

   Axis V (GAF Score):_____

4. In addition to DSM-IV criteria, how did you arrive at your diagnosis?

   ☐ Structured or unstructured interviews with the student
   ☐ Interviews with other persons
   ☐ Behavioral observations
   ☐ Developmental history
   ☐ Educational history
   ☐ Medical history

☐ Neuro-psychological testing. Date(s) of testing? _____
☐ Psycho-educational testing. Date(s) of testing? _____
☐ Standardized or non-standardized rating scales
☐ Other. (Please specify) _____

5. What is the severity of the disorder? ☐ **Mild** ☐ **Moderate** ☐ **Severe**

Please describe the severity checked above:

_____

_____

_____

6. What is the expected duration of this disability?

_____

_____

_____

_____

_____

7. Major Life Activities Assessment:

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

Life Activity	Negligible	Moderate	Substantial	Don't Know
Concentrating	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Eating	☐	☐	☐	☐
Social Interactions	☐	☐	☐	☐
Self Care	☐	☐	☐	☐
Regular Attendance	☐	☐	☐	☐
Keeping appointments	☐	☐	☐	☐
Stress Management	☐	☐	☐	☐
Managing internal distractions	☐	☐	☐	☐
Managing external distractions	☐	☐	☐	☐

Sleeping	☐	☐	☐	☐
Organization	☐	☐	☐	☐

8. Please describe the student's symptoms relating to this diagnosis.

_____
_____
_____
_____
_____
_____
_____
_____

9. What specific symptoms does the student have that might affect the student's academic performance?

_____
_____
_____
_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____

11. Is this student currently receiving therapy or counseling?

☐ Yes ☐ No ☐ Not Sure

12. What medications is the student currently taking? How effective is the medication? How might side effects, if any, affect the student's academic performance?

_____

_____

_____

_____

_____

_____

13. 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. Indicate why the accommodations are necessary.

_____

_____

_____

_____

_____

_____

_____

_____

14. 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.

_____

_____

_____

_____

_____

_____

HEALTHCARE PROVIDER INFORMATION

(Please sign and date below and fill in all other fields completely using PRINT or TYPE)

Provider Signature: _____ **Date**: _____

Provider Name (Print): _____

Title: _____

License or Certification #: _____

Address: _____

_____

Phone Number: (_____) _____-_____

FAX Number: (_____) _____-_____