

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 currently 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.

\_\_\_\_\_

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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.

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

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## 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

Fax: (920) 693-1827