PSYCHIATRIC DISABILITY VERIFICATION

Services for Students with Disabilities (SSWD) determines reasonable academic 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 receive academic accommodations, the documentation needs to show functional limitations that will impact an individual in an academic setting.

The SSWD Office requires current comprehensive documentation in order to determine appropriate services and accommodations based on functional limitations that may impact the student in the academic setting. The information listed below has been developed to assist the student in working with the treating/diagnosing professional(s) in obtaining the specific and necessary information to evaluate requests for academic assistance based on the diagnosis.

**All information requested must be completed by the medical professional as thoroughly as possible.** Inadequate information and/or incomplete forms will delay the eligibility review process. All answers to the questions on the form must be legible. It is recommended that answers to the form be **typed**; illegible handwriting will delay the eligibility review process since the provider will be contacted for clarification.

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

The information provided will not become part of the student’s educational records and will be kept in the student’s confidential file at the SSWD Office.

The ADA Coordinator in the Distance Learning Center is the authorized liaison between the two offices. The student’s point of contact will be Marcia Rako – ADA Coordinator. Marcia can be reached at rakom@uwplatt.edu or 800-362-5460.
DIAGNOSTIC INFORMATION
(Please Print Legibly or Type)

Student name: _______________________________ Date: __________________

Please 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 discusses the results.

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 clinical interviews with the individual
   □ Interviews with other individuals
   □ 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. Severity of the condition loss (check one): □ mild   □ moderate   □ substantial
Describe the severity checked above.

6. What is the expected duration of this disability? ____________________________

7. Is the student currently receiving therapy or counseling?  yes  no

8. Does the student plan to continue counseling or therapy with you over the course of the semester?  yes  no

9. Major Life Activities Assessment

A student must have a substantial limitation in a major life activity to receive accommodations at the post secondary level.

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

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<thead>
<tr>
<th>Life Activity</th>
<th>Negligible</th>
<th>Moderate</th>
<th>Substantial</th>
<th>Not Applicable</th>
<th>Don’t Know</th>
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<tbody>
<tr>
<td>Eating</td>
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<td>Social Interactions</td>
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<td>Caring for Oneself</td>
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<td>Keeping Appointments</td>
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<td>Stress Management</td>
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<td>Managing internal distractions</td>
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<td>Sleeping</td>
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<td>• Reading</td>
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<td>• Writing/Spelling</td>
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<td>• Calculating</td>
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<td>• Listening</td>
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<td>• Thinking</td>
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<td>• Concentrating</td>
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<td>• Memorizing</td>
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10. Describe how the functional limitations rated above as substantial will affect the student in an academic setting.
11. What medication(s) is the student currently taking? How effective is the medication(s)? How might side effects, if any, affect the student's academic performance?

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

13. 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 (e.g. if a note taker is suggested, state the reasons for this request related to the student's diagnosis).

14. If current treatments (e.g. medications, counseling, etc.) are successful, state the reasons why the above academic adjustments/accommodations/services are necessary. Please be specific.

15. Is there anything else you would like us to know about this student?
PROVIDER INFORMATION
(Please sign and complete fully in Print or Type)

Signature: __________________________ Date: __________________

Print Name: ______________________________________________

Title: ______________________________________________________

License or Certification #: __________________________________

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

Office phone: (______)-_______-___________

FAX Number: (______)-_______-___________

Email__________________________________

These guidelines are not meant to be used exclusively or as a replacement for direct communication with UW-Platteville Services for Students with Disabilities regarding the individual nature of a disability. While submitted documentation meeting the above guidelines may be acceptable to the University of Wisconsin-Platteville it is important to be mindful that they may/may not meet the documentation guidelines required in other academic or testing organizations.