**University of Wisconsin-Stevens Point**
Disability Resource Center

# PSYCHOLOGICAL DOCUMENTATION

**(To be completed by a qualified medical doctor/physician, psychiatrist, psychologist, counselor, etc.)**

## Introduction

The Disability Resource Center provides academic services and accommodations for students with disabilities. Students are required to provide documentation that verifies that a diagnosed condition meets the legal definition of a disability covered under Section 504 of the Rehabilitation Act (1973) and the Americans with Disabilities Amended Act (2008). These laws define a disability as a physical or mental impairment that ***substantially limits*** one or more major life activities. Eligibility for academic accommodations is based on documentation that clearly demonstrates a student has one or more functional limitations in an academic setting, and that one or more accommodations is needed to achieve equal access.

A client of yours has requested disability-related services. As this client's treating clinician/specialist, you are asked to provide the following information to allow the university to consider this client's service request(s). *Incomplete responses may result in a delay of establishing accommodations.*

**Student Name: _____ Date of Birth: _____**
***(Please type or print neatly. Use a separate paper if needed)***

1. **Diagnosis: DSM-IV-R or DSM-V Diagnosis?**

| | |
|---|---|
| | |
| | |
| | |
| **Are there any diagnoses that need to be ruled out?** | |

2. **In addition to applying DSM-IV-R diagnostic criteria, what other information did you collect to arrive at your diagnosis?**
   - ☐ Behavioral observations
   - ☐ Developmental history
   - ☐ Rating scales
   - ☐ Medical history
   - ☐ Structured or unstructured clinical interview with the student
   - ☐ Interviews with others (parents, teachers, spouse or significant others)
   - ☐ Neuropsychological or psycho educational testing Date(s) of testing: _____
   - ☐ Other (Please specify) _____

   ***(Please attach/fax diagnostic report of assessment)***

3. **What methods were utilized to assess functional limitations? Please list below:**

4. **Date diagnosis was determined: _____**
5. **Date of first contact with student: _____**
6. **Date of last contact with student: _____**
7. **If student is taking medications related to this condition, please list medications and the effectiveness:**

*Continued on next page*

8. **Has this student been hospitalized or received in-patient care for their disorder in the past? Yes No**

9. **If yes, what has been the frequency and typical duration of these treatments?**

10. **Symptom Assessment: Please rate frequency/duration and severity (using "x") of the symptoms as related to the disability.**

| Symptom | Frequency/Duration 0-4 scale: 0=never, 1=rarely, 2=intermittent 3=daily/frequent, 4=chronic | Severity | | | |
|---|---|---|---|---|---|
| | | Unknown N/A | Mild | Moderate | Severe |
| **Compulsive Behaviors** | | | | | |
| **Delusions** | | | | | |
| **Depressed Mood** | | | | | |
| **Disordered Eating** | | | | | |
| **Fatigue/Loss of Energy** | | | | | |
| **Hallucinations** | | | | | |
| **Impulsive Behaviors** | | | | | |
| **Mania** | | | | | |
| **Obsessive Thoughts** | | | | | |
| **Panic Attacks** | | | | | |
| **Phobia (specify_____)** | | | | | |
| **Physiological Symptoms:** | | | | | |
| **Dizziness** | | | | | |
| **Fainting** | | | | | |
| **Racing Heart** | | | | | |
| **Migraines/Headaches** | | | | | |
| **Nausea** | | | | | |
| **Chest Pain** | | | | | |
| **Other_____** | | | | | |
| **Racing thoughts** | | | | | |
| **Self-Injurious Behavior** | | | | | |
| **Suicidal Ideation** | | | | | |
| **Suicide Attempts** | | | | | |
| **Unable to Leave the House** | | | | | |
| **Other:** | | | | | |

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**Functional Impact Assessment: Please rate the frequency/duration and severity (using "x") of the condition's impact on major life activities to the best of your knowledge. For comparison purposes, please use same age peers in a postsecondary setting.**

| Symptom | Frequency/Duration 0-4 scale: 0=never, 1=rarely, 2=intermittent 3=daily/frequent, 4=chronic | Severity | | | |
|---|---|---|---|---|---|
| | | Unknown N/A | Mild | Moderate | Severe |
| **Initiating Activities** | | | | | |
| **Speaking** | | | | | |
| **Listening** | | | | | |
| **Sitting** | | | | | |
| **Concentration** | | | | | |
| **Following Directions** | | | | | |
| **Memorization** | | | | | |
| **Persistence** | | | | | |
| **Processing Speed** | | | | | |
| **Organizational Skills** | | | | | |
| **Working** | | | | | |
| **Interacting with Others** | | | | | |
| **Sleeping** | | | | | |
| **Sustained Reading** | | | | | |
| **Sustained Writing** | | | | | |
| **Problem Solving** | | | | | |
| **Other:** | | | | | |

**11.** If applicable, state **specific accommodation recommendations** for this student, and a **rationale** as to why the accommodation is necessary (e.g. if a note taker is suggested, explain how this accommodation is related to the student's diagnosis).

| Accommodation Recommendation | Rationale |
|---|---|
| | |
| | |
| | |

**Professional's Signature: _____ License #: _____**

**Print or type name and title: _____**

**Clinic or Medical Facility: _____**

**Address: _____**

**Phone: _____ Date: _____**

**Please address questions regarding documentation, and send this documentation to:**

**UWSP Disability Resource Center**
**1801 Fourth Avenue/CCC 108**
**Stevens Point, WI 54481**

**Phone: 715- 346-3365**
**Fax: 715 346-4143**
**Email: drc@uwsp.edu**

**Adopted from the McBurney Disability Resource Center at UW Madison*