UNIVERSITY of WISCONSIN
GREEN BAY

Student Accessibility Services

VERIFICATION OF PSYCHOLOGICAL DISORDER

Student Accessibility Services 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.**

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 not major life activities are not significantly impacted, no accommodations may be considered.***

_____

_____

_____

_____

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?

_____

_____

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

_____

_____

_____

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 limitation. Indicate why the accommodations are necessary.

_____

_____

_____

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

_____

_____

Provider Information

Name:	**Date:**	
Medical Specialty:		**License #:**
Address:		
Phone:	**Email:**	
Clinician's Signature:		**Printed Name:**

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

Student Accessibility Services
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Green Bay, WI 54311

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FAX 920-465-2191
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