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

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Medical Specialty:</td>
<td>License #:</td>
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<tr>
<td>Address:</td>
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<tr>
<td>Phone:</td>
<td>Email:</td>
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<tr>
<td>Clinician’s Signature:</td>
<td>Printed Name:</td>
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</tbody>
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Please mail or fax this completed form and any additional information to:

Student Accessibility Services
UW-Green Bay
2420 Nicolet Drive, SS 1700
Green Bay, WI 54311
920-465-2841
FAX 920-465-2191
EMAIL: SAS@UWGB.EDU