Psychological Disability Documentation Instructions and Form
Updated December, 2015

Student Instructions and Information:

- Students must submit current documentation to Accessibility Services.
  - Current documentation is defined as:
    - Documentation that reflects data collected within three years at the time of request for services.
    - It is at the Accessibility Services counselor’s discretion to make appropriate exceptions to this policy and/or to request a reevaluation and more recent documentation in order to establish the most appropriate accommodations.
- A qualified provider (medical doctor, psychologist, or psychiatrist) must provide the documentation.
- In place of this form, a letter may be provided including all of the requested information. Any letters must be on letterhead from the provider’s practice. Any documentation must include the provider’s signature and credentials.
- Students are asked to provide documentation prior to the intake meeting if at all possible. It is during the intake meeting that appropriate accommodations, and the process for using the accommodations, will be discussed.
- Documentation can be submitted in person or by mail to the UWG Counseling Center, 123 Row Hall, Carrollton, GA 30118, by fax to 678-839-6429, or by email to counseling@westga.edu.

To be Completed by Student:

Name (Last, First, Middle): __________________________________________________________

Date of Birth: ___________________ UWG ID Number: 917__________________________

Cell Phone: ___________________ Alternate Phone: _________________________________

Home Address: _________________________________________________________________

______________________________________________________________________________

Email Address: _________________________________________________________________

Status (Check One): ____Current Student   ____ Transfer Student   ____ Prospective Student
To be Completed by Provider:

The Office of Accessibility Services establishes academic and/or housing accommodations for students with a documented disability. The Americans with Disabilities Act (ADA) defines a disability as a physical or mental impairment that substantially limits one or more major life activities. The University System of Georgia Board of Regents (USGBOR) requires current and comprehensive documentation for any diagnosis of a disability in order for disability services providers to determine appropriate accommodations and services. Please see Appendices D-H of the USGBOR Academic and Student Affairs Handbook for more information.

Primary Diagnosis: ________________________________

DSM-5 Code: ________________________________ Date of Diagnosis: ________________

Secondary Diagnosis: ________________________________

DSM-5 Code: ________________________________ Date of Diagnosis: ________________

Please provide the diagnostic criteria and methodology used to diagnose the condition.

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Please check any of the following as appropriate to describe the patient’s symptoms and/or behavioral manifestations.

___ Feeling sad or down
___ Confused thinking or reduced ability to concentrate
___ Excessive fears or worries
___ Extreme feelings of guilt
___ Feelings of worthlessness or self-hate
___ Extreme mood changes of highs and lows
___ Withdrawal from friends and activities
___ Significant tiredness, low energy
___ Problems sleeping or excessive sleeping
___ Detachment from reality (delusions), paranoia or hallucinations
___ Inability to cope with daily problems or stress
___ Trouble understanding and relating to situations and to people
___ Other

___ Alcohol or drug abuse
___ Major changes in eating habits
___ Sex drive changes
___ Excessive anger, hostility or violence
___ Suicidal thinking
___ Agitation, restlessness, and irritability
___ Feelings of hopelessness and helplessness
___ Heart palpitations
___ Chest pain
___ Rapid heartbeat
___ Headaches
___ Sweating
___ Nausea/vomiting
___ Tremors/shaking
___ Other

___ Other

___ Other
Please describe the history and severity of the disorder.

__________________________________________________________________________________________
__________________________________________________________________________________________

Is it expected that the patient’s functioning and/or severity of the disorder will change over time?

_____ Yes  _____ No

If yes, please explain the anticipated progression.

__________________________________________________________________________________________
__________________________________________________________________________________________

Please check all of the following as appropriate to describe the patient’s functional limitations. This list of possible functional limitations is from the Center for Psychiatric Rehabilitation, 1997 (http://www.washington.edu/doit/what-are-some-functional-limitations-related-mental-illness).

_____ **Difficulty with medication side effects:** side effects of psychiatric medications that affect academic performance include drowsiness, fatigue, dry mouth and thirst, blurred vision, hand tremors, slowed response time, and difficulty initiating interpersonal contact.

_____ **Screening out environmental stimuli:** an inability to block out sounds, sights, or odors that interfere with focusing on tasks. Limited ability to tolerate noise and crowds.

_____ **Sustaining concentration:** restlessness, shortened attention span, distraction, and difficulty understanding or remembering verbal directions.

_____ **Maintaining stamina:** difficulty sustaining enough energy to spend a whole day of classes on campus; combating drowsiness due to medications.

_____ **Handling time pressures and multiple tasks:** difficulty managing assignments, prioritizing tasks, and meeting deadlines. Inability to multi-task work.

_____ **Interacting with others:** difficulty getting along, fitting in, contributing to group work, and reading social cues.

_____ **Fear of authority figures:** difficulty approaching instructors and/or teaching/lab assistants.

_____ **Responding to negative feedback:** difficulty understanding and correctly interpreting criticism or poor grades. May not be able to separate person from task (personalization or defensiveness due to low self-esteem).

_____ **Responding to change:** difficulty coping with unexpected changes in coursework, such as changes in the assignments, due dates, or instructors. Limited ability to tolerate interruptions.

_____ **Severe test anxiety:** such that the individual is rendered emotionally and physically unable to take the exam.

_____ Other___________________________________________________

_______________________________________________________________
Please provide any additional information/context as appropriate concerning the functional limitations.

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__________________________________________________________________________________________
__________________________________________________________________________________________
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Please provide any recommendations to address the indicated functional limitations.

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**Please attach any psychological and/or educational reports that support the diagnosis** and complete the following information:

Provider Name:______________________________________________________________________________

Title:______________________________________________________________________________________

License #:__________________________________________________________________________________

Practice Name and Address:___________________________________________________________________

__________________________________________________________________________________________

Phone:________________________________Fax:________________________________

Email:____________________________________________________________________________________

Provider Signature (REQUIRED):________________________________________________________________

Date of Signature:__________________________________________________________________________