

## 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](mailto: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.

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

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| <input type="checkbox"/> Feeling sad or down   | <input type="checkbox"/> Alcohol or drug abuse                     |
| <input type="checkbox"/> Confused thinking or reduced ability to concentrate             | <input type="checkbox"/> Major changes in eating habits            |
| <input type="checkbox"/> Excessive fears or worries                                      | <input type="checkbox"/> Sex drive changes                         |
| <input type="checkbox"/> Extreme feelings of guilt                                       | <input type="checkbox"/> Excessive anger, hostility or violence    |
| <input type="checkbox"/> Feelings of worthlessness or self-hate                          | <input type="checkbox"/> Suicidal thinking                         |
| <input type="checkbox"/> Extreme mood changes of highs and lows                          | <input type="checkbox"/> Agitation, restlessness, and irritability |
| <input type="checkbox"/> Withdrawal from friends and activities                          | <input type="checkbox"/> Feelings of hopelessness and helplessness |
| <input type="checkbox"/> Significant tiredness, low energy                               | <input type="checkbox"/> Heart palpitations                        |
| <input type="checkbox"/> Problems sleeping or excessive sleeping                         | <input type="checkbox"/> Chest pain                                |
| <input type="checkbox"/> Detachment from reality (delusions), paranoia or hallucinations | <input type="checkbox"/> Rapid heartbeat                           |
| <input type="checkbox"/> Inability to cope with daily problems or stress                 | <input type="checkbox"/> Headaches                                 |
| <input type="checkbox"/> Trouble understanding and relating to situations and to people  | <input type="checkbox"/> Sweating                                  |
| <input type="checkbox"/> Other _____   | <input type="checkbox"/> Nausea/vomiting                           |
|  | <input type="checkbox"/> Tremors/shaking                           |

Other \_\_\_\_\_

Other \_\_\_\_\_

Please describe the history and severity of the disorder.

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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.

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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/doi/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 \_\_\_\_\_

Other \_\_\_\_\_  
\_\_\_\_\_

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: \_\_\_\_\_