UNIVERSITY OF WEST GEORGIA

Psychological Disability Documentation Instructions and Form

Updated January 2023

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 Accessibility Services, 123 Row Hall, Carrollton, GA 30118, by fax to 678-839-6429, or by email to accessibility-services@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
___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_____

_____

_____Other_____
_____

_____Other_____
_____

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

_____

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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:_____