UNIVERSITY OF CALIFORNIA, SAN DIEGO UCSD

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UC SAN DIEGO DIVISION OF EXTENDED STUDIES
STUDENT SERVICES
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JOLLA, CALIFORNIA 92093-0176
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Documentation Form for Psychological Disabilities

The student below has requested accommodations on the basis of a Psychological Disability through Student Services at UC San Diego Division of Extended Studies.

In order to verify the disability, its severity, its impact on one or more major life activities, and to determine reasonable accommodations, your diagnosis and assessment of this student is needed. Documentation must be current (i.e. most recent visit should be within the last 3 months). In some cases, students will be required to provide more frequent updates depending upon the fluid nature of their disability. Please include copies of any relevant adult-normed psycho-educational or neuropsychological assessments, including test scores. All information will be kept confidential.

Attached is the "University of California Practices for the Documentation and Academic Accommodation of Students with Psychological Disabilities" to assist you in completing this form thoroughly and completely.

Student Name _____ DOB _____

Student ID Number _____

Name/Title of Certifying Professional (Please print) _____

License # _____ State _____

Address _____

Telephone Number _____ Fax Number _____

Student Name _____

Student Authorization:

I, _____, am requesting academic support services through UC San Diego Division of Extended Studies Student Services. They require current and comprehensive documentation of my disability/medical condition prior to receiving services through UC San Diego Division of Extended Studies. I acknowledge that by requesting academic accommodations, I am authorizing the UC San Diego Division of Extended Studies Student Services Disability Coordinator to discuss information relevant to my disability with my medical provider. I understand UC San Diego Division of Extended Studies will keep my information confidential as per UC Policy and Procedures Manual Section 160-2.

Student Signature: _____ **Date:** _____

Provider Certification:
I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above. In cases where the diagnostic assessment of the student was performed by another clinician, my signature confirms the review of the original assessment and agreement of the diagnosis.

OR

If you feel you **CANNOT** provide documentation for this student, please indicate the reason below:

____ I am not treating this student

____ I have referred to another clinician

____ I would need additional sessions with the student to complete this form

____ Other _____

____ I have not diagnosed this student

____ I have referred for additional evaluation

____ I have insufficient information to describe functional limitations that would impact the student's academic work/major life activities

Provider Signature: _____ **Date:** _____

Student Name _____

DSM-5: Please include all relevant diagnostic information including subtypes and/or specifiers for diagnostic domains and subgroups (as indicated in DSM-5) including V/Z codes: psychosocial and environmental stressors.

1. What are the current diagnoses for this student? (Please provide all pertinent DSM-5 codes or diagnoses.)

   Primary: _____
   Secondary: _____

   Psychosocial or Environmental Stressors: _____

   Medical Conditions:_____

2. What is the initial date of the diagnosis(es)? _____

3. Is the student currently under your care for this diagnosis(es)? YES NO

4. When did **you** first see/treat the student for this diagnosis(es)? _____

5. List the dates you saw the student within the last 6 months for this diagnosis(es)? _____
   _____

6. Has this student ever been hospitalized for psychological issues?
   NO YES (dates of hospitalization) _____

7. Has this student ever attempted suicide?
   NO YES (dates) _____

8. Level of Severity without Treatment: Mild 1 2 3 4 5 Moderate 6 7 8 9 10 Severe

   Level of Severity with Treatment: Mild 1 2 3 4 5 Moderate 6 7 8 9 10 Severe

9. Please indicate which of the following assessments or evaluation procedures were used to arrive at the diagnosis(es). Include copies of any neuropsychological or psycho-educational testing including test scores.

   [ ] Structured/Unstructured Interviews with the Student
   [ ] Interviews with Others
   [ ] Behavioral Observations
   [ ] Developmental History
   [ ] Educational History
   [ ] Medical History
   [ ] Neuropsychological Testing (dates) _____
   [ ] Psycho-educational Testing (dates) _____
   [ ] Standardized or Non-Standardized Ratings Scales
   [ ] Other (specify) _____

10. Describe the student's **current and specific functional limitations** that result from the impairment's impact on the activities listed in Question 11, particularly with regard to an academic environment.
    _____
    _____
    _____

Student Name _____

11. Activities Assessment: Please check which of the activities are affected because of the diagnosis(es)/impairment(s) and indicate the level of limitation ***with current treatment protocols***. Please assess all activities and indicate if you observed them and/or if they are self-reported by the student. If not applicable, please check the box marked 'No Impact.'

Activity	No Impact	Mild Impact	Moderate Impact	Severe Impact	Don't Know	**Self-Report**	**Observed by Medical Professional**
Organization							
Concentration							
Memory							
Time Management							
Stress Management							
Sleeping							
Social Interactions							
Attendance							
Managing Distractions							

12. Describe any medications currently being used by the student including type, dosing, effectiveness, and side effects. How frequently has medication been changed?
    _____
    _____
    _____

13. Explain how medication modifies the impact that the disability has on the student's condition.
    _____
    _____
    _____

14. What compensatory strategies are you working with the student on to mitigate the psychological condition? (i.e. coping skills, anxiety-reduction techniques, focusing therapy, time management, etc.)
    _____
    _____
    _____

15. Is the student compliant with his/her treatment plan, medication protocols and/or recommended referrals? YES NO

16. What is the student's prognosis?
    _____
    _____

17. Please attach any supporting documentation.