RUTGERS
Office of Disability Services
Helping you access Rutgers, everywhere!

Office of Disability Services
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Documentation of a Psychological Disability

Student's First Name:

Student's Last Name:

Today's Date:

Date of Diagnosis:

Date Student was Last Seen:

How long have you been treating the student?

Frequency of Appointments:
- ☐ Once a week
- ☐ Twice a week
- ☐ Once a month
- ☐ Once every six months
- ☐ Once a year
- ☐ On an as-needed basis
- ☐ Other:

DSM-5 Diagnosis/ICD-10 Code(s)

What is the expected duration of the condition?

- ☐ Short-term (less than 6 months)
- ☐ Episodic
- ☐ Long-term (6 months - 1 year)
- ☐ Chronic (longer than 1 year with frequent recurrence)

In addition to the DSM-5 criteria, how did you arrive at your diagnosis? Please check all relevant items.

☐ Structured or unstructured interviews with the person him/herself
☐ Interviews with other persons
☐ Behavioral observations
☐ Developmental history
☐ Educational history
☐ Medical history
☐ Neuropsychological testing
☐ Psychoeducational testing
☐ Standardized or unstandardized rating scales
☐ Other:

If you selected Neuropsychological Testing, please provide the testing date.

If you selected Psychoeducational Testing, please provide the testing date.

Is the student currently taking any medication? ☐ Yes ☐ No

If yes, please provide information on each medication below.

Medication/Dosage/ Frequency (e.g., Celebrex, 200mg, 1x daily)	
Side effects of medication	

FUNCTIONAL LIMITATIONS

	No impact	Moderate impact	Substantial impact	Don't Know
Concentration	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Sleep/Waking	☐	☐	☐	☐
Eating	☐	☐	☐	☐
Social interaction	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐
Managing internal Distractions	☐	☐	☐	☐
Managing external distractions	☐	☐	☐	☐
Complex/Abstract thinking	☐	☐	☐	☐
Attending class regularly and on time	☐	☐	☐	☐
Making and keeping appointments	☐	☐	☐	☐
Stress management	☐	☐	☐	☐
Organization and prioritization of task(s)	☐	☐	☐	☐
Stress management	☐	☐	☐	☐
Other	☐	☐	☐	☐

If on medication, how does it impact the functional limitations listed above?

What symptoms are you hoping accommodations will target/mitigate? Are there any specific accommodations you might recommend that would help the student?

Is there anything else you think we should know about the student's psychological disability?

PROVIDER INFORMATION

Role of the individual completing this form (check all that apply).

- ☐ Treating Professional
- ☐ Psychotherapist
- ☐ Medication Supervisor
- ☐ Other Treating Professional
- ☐ Evaluator
- ☐ Second Opinion Evaluator
- ☐ Other _____

Provider full name:	
License number:	
Profession:	
Provider's address:	
Provider's phone number:	
Fax number:	
Provider's e-mail address:	