RUTGERS
Office of Disability Services

Office of Disability Services
Lucy Stone Hall, Suite A145
Rutgers, The State University of New Jersey
54 Joyce Kilmer Avenue
Piscataway, NJ 08854

ods.rutgers.edu
ods@echo.rutgers.edu

p. 848-445-6800
f. 732-445-3388

Documentation of a Psychological Disability

Student's First Name:

Student's Last Name:

Today's Date:

Date of Diagnosis :

Date Student was Last Seen:

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-IV Diagnosis

Please feel free to use DSM-V categories if that is how you diagnosed the student.

Axis I

Axis II

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Axis III

Axis IV

Axis V (GAF) Score:
Present time:

Average over last year

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 DSM-IV 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

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If you selected Neuropsychological, please provide the date of the testing

If you selected Psychoeducational testing, please provide the date of the testing

Is the student currently taking any medication?

- ○ Yes
- ○ No

If yes above, please provide information on each medication below:

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

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Without Medication/Mitigation

	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	○	○	○	○
Other	○	○	○	○

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With Medication/Mitigation

	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 Tasks	○	○	○	○
Other	○	○	○	○

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Please list the student's current symptoms. Then indicate what reasonable academic accommodations would be related to the symptom indicated. More detailed information regarding reasonable academic accommodations can be found at: reasonable accommodations.

Example: Symptom "Due to the student's depression, the student has difficulty concentrating."

Recommended Accommodation: Due to the difficulty concentrating, the student will require extra time on tests.

Symptom 1:

Recommended Reasonable Accommodation:

Symptom 2:

Recommended Reasonable Accommodation:

Symptom 3:

Recommended Reasonable Accommodation:

What is the student's prognosis?

How long do you anticipate that the student's academic achievement will be impacted by his/her disability?

Please select one option

- ◯ 6 months
- ◯ 1 year
- ◯ More than 1 year

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

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

- ☐ Treating Professional
- ☐ Psychotherapy
- ☐ Medication Supervision
- ☐ Other Treating Professional
- ☐ Evaluator
- ☐ 2nd Opinion Evaluator
- ☐ Other

Please enter your Full Name

License Number

Profession

Provider's Address

Provider's Phone #

Fax #

Provider's Email Address