Psychological/Emotional Health Disabilities Documentation Form

Federal law requires that students' requests for academic adjustments, auxiliary aids, and other accommodations be determined on a case-by-case basis. This form was created to facilitate the individualized review of each student's request and to assist Student Disability Services (SDS) in developing an appropriate accommodation plan together with the student.

The information submitted to SDS should reflect the most currently available information. **This Psychological/Emotional Health Documentation Form should be:**

a) ***Completed by a qualified professional.*** The diagnosing professional may not be related to the student;
b) ***Completed as clearly and thoroughly as possible.*** Incomplete responses and illegible handwriting may require additional follow up that could delay the review process;
c) ***Supplemented with any evaluative reports that may provide a more complete understanding of the student's accommodation needs.*** Evaluative reports may include comprehensive diagnostic reports such as psycho-educational or neuropsychological reports. Please do not provide case notes or rating scales without a narrative that explains the results; and
d) ***Submitted to Student Disability Services.*** All documentation will be held strictly confidential as a student record.

Please mail, email, or fax information to Student Disability Services at:
100 Dunford Hall/915 Volunteer Blvd.
Knoxville, TN 37996-4020
Email: sds@utk.edu
Fax: (865) 974-9552

Date: ___________________

Student Name: ____ Birthdate: ______________

1. Date of first contact with this individual: _______________

   Date of last contact with this individual: _______________

2. DSM-V Diagnoses:

Primary Diagnosis and DSM-V Code: ____

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Secondary Diagnosis and DSM-V Code:____

____

Tertiary Diagnosis and DSM-V Code: ____

____

3. How did you arrive at your diagnoses? Please check all that apply.

____ Behavioral Observations
____ Developmental History
____ Educational History
____ Medical History
____ Clinical Interview (Structured or Unstructured)
____ Interviews with Others
____ Rating Scales (Please specify types: ____)
____ Neuropsychological or Psychoeducational Testing (Dates of testing: ________________________)

4. Rate the level of functional limitation you believe your patient experiences, or will experience, ***in the college environment***.

0 = No problem   1 = Mild   2 = Moderate   3 = Severe

Life Activities:

____ Caring for oneself
____ Social Interactions
____ Sitting
____ Eating
____ Processing Speed
____ Regular Attendance
____ Stress Management
____ Managing Internal Distractions

____ Working
____ Interacting with Others
____ Sleeping
____ Managing External Distractions
____ Organizing
____ Memorizing
____ Concentrating

5. What ***specific symptoms*** might affect the student's academic performance?

6. Describe any ***currently prescribed medication***, including dosage, side effects, and effectiveness.

7. Share any ***specific*** recommendations regarding academic accommodations in a post-secondary environment for this student. Include a ***rationale*** relevant to this student's functional limitations.

Healthcare Provider Information

Provider Name (Print): ____

Provider Signature: ____

License or Certification #: ____

Address: ____

Phone: ________________________________ FAX: ________________________________

By signing this form, the healthcare professional certifies that they are an appropriately credentialed or licensed professional trained in psychiatric, psychological, or neuropsychological assessment.