

Center for Access-Ability Resources
University Health Service
Northern Illinois University
DeKalb, Illinois 60115
Phone: (815) 753-1303 Fax:(815) 753-9570

Psychiatric Disability Documentation

The student, whose name and signature appear below, has requested support services based on the diagnosis of a psychiatric disability. Students requesting such services from the Northern Illinois University Center for Access-Ability Resources are required, under Section 504 of the Federal Rehabilitation Act of 1973, to submit documentation to verify eligibility. This form must be completed by a psychiatrist, licensed psychologist, certified social worker (CSW or ACSW) or a licensed professional counselor. **Please either complete and return this form, and/or send copies of diagnostic evaluation and progress reports (containing the requested information), to the name and address listed above.** Please consider this signed consent as authorization to release this information to the Center for Access-Ability Resources.

Student Name

Student Signature

Date

Birthdate

Social Security Number or ZID

Please note: Accommodations will be provided only upon receipt of complete and adequate documentation.

DSM-IV Diagnosis/Diagnostic Code:

Axis I

Axis II

Axis V

Date of Diagnosis _____ **Date of last contact with student** _____ **Date of initial contact**

Psychological Assessment Instruments and Results:

Medications:

Current medications (dosage and side effects):

Long term medication plan:

Current compliance with medical plan:

Student's Name: _____ ZID: _____

Expected Duration of Conditions (chronic, episodic, or short-term):

Therapeutic Interventions (prognosis, current compliance):

History of Hospitalization:

Does this person pose a threat to themselves or others (explain)?

Functional Impact (current functional impact on physical, perceptual and cognitive abilities):

Level of Current Functioning (even with benefits of treatment):

Impairment of Learning Abilities (difficulty with concentration, memory, slow processing speed, etc.):

Is this student aware of any realistic regarding how the disability may impact academic performance?

Are there any types of test or classes that would cause more difficulty for this student?

Student's Name: _____ ZID: _____

Recommendation for Accommodation and/or Support Services:

From the list below, indicate which, if any, of these accommodation would be appropriate:

- _____ Consultation with faculty to advocate for this student
- _____ Notetakers to supplement this student's notes
- _____ Taped textbooks and assistance in ordering taped books
- _____ Restructuring of class assignments
- _____ Time extension on class assignments
- _____ Time extension on exams: _____ Time and one half _____ Double Time _____ Low-distraction room
- _____ Other _____

Additional Suggested Academic/Instructional Accommodations:

Professional Credentials:

Signature of Certifying Professional

Print Name / Title

License/Certification Number & State of License

Address

Phone

Date

Please direct any question regarding completion of this form and the nature of information needed for students with psychiatric impairments, to the Center of Access-Ability Resources. Please return this from to the name and address on the letterhead. Thank you.