STUDENT DISABILITY RESOURCE CENTER
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FORM FOR DOCUMENTING PSYCHIATRIC AND LEARNING DISABILITIES

The outline below was designed to help the student in working with the treating or diagnosing healthcare professional in obtaining the specific information to evaluate eligibility for academic accommodations.

1) **This form is to be filled out by healthcare professionals qualified to diagnose and recommend accommodations for students with psychiatric or learning disabilities.**
2) **All parts of the form must be completed as thoroughly as possible**. Inadequate information, incomplete answers, and/or illegible handwriting will delay the eligibility review process by necessitating follow-up contact for clarification.
3) **The health care provider should attach any reports which provide additional related information.** In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment.

Please note that this does not guarantee accommodations or services. Further assessment and collaboration between the student and the Student disAbility Resource Center are needed.

AUTHORIZATION FOR RELEASE OF PRIVATE MEDICAL INFORMATION*

TO: _____
(Medical/mental health care professional and/or clinic, medical practice, or hospital)

Under the Health Care Information Privacy Accountability Act (HIPAA), and the Federal Education Rights and Privacy Act (FERPA), I, _____, authorize and order that the following information requested on the attached medical release form from California State University Dominguez Hills be completed in total, by an appropriately licensed professional (as applicable) and returned as soon as possible to the student or the Student disAbility Resource Center at California State University Dominguez Hills.

This confidential information will be used to ascertain the educational and functional limitations imposed upon me by my disability, per the requirements for academic accommodation and services under Title V of the California Educational Code, Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act of 1990. Further, I authorize and order that the information requested on the attached form from Alliant International University be transmitted in writing, via United States Mail, facsimile, or electronically, in as expeditious a manner as possible.

This release can be revoked at any time by me with proper notification in writing, and automatically upon my completion or departure from my studies at California State University Dominguez Hills.

I hereby authorize and order the completion of this order for medical information made b me on this day of -_____. I certify that this authorization is made of my own volition, fully in compliance with Federal and State Laws.

_____ _____
Printed Name of Student *Signature of Student*

Date Signed: _____Date of Birth: _____Student ID#: _____

*Note: Medical providers may require additional or alternative release forms.

I. Identifying Information: *To be filled out by the student.*

Name: _____

Address: _____

Date of Birth: _____

Student ID: _____

II. Professional Diagnosing Condition/Treatment Information

The Professional must be qualified to diagnose a psychiatric disability. If medication is involved, a psychiatrist is preferred.

Today's Date: _____

1. Please indicate your profession (circle one):

Psychologist Psychiatrist Medical Doctor Licensed Professional Counselor

Clinical Social Worker Marriage Family Therapist

2. How long has this student been under your care? _____
3. When was the last time you saw this student? _____

III. Diagnostic Information

1. Date of onset of condition: _____
2. DSM-5 diagnosis and ICD-10 Code: _____
3. Did you make the diagnosis? Yes No

   If not, who did? _____
4. Severity of Condition (circle one):

   Mild Moderate Severe
5. Is the condition: Acute or Chronic?
6. Prescribed Medication(s): _____
7. Current treatment: _____

   _____
8. Are there any co-existing conditions (physical, mental, cognitive) that should be considered in the accommodation plans? _____

   _____
9. What is the prognosis of the condition? _____
10. Are there any factors that may exacerbate the condition? _____

IV. Method of Assessment

Method	Indicate which method was utilized
Interview with the student	
Interviews with other persons	
Behavioral observations	
Developmental history	
Educational history	
Medical history	
Rating scales	
Neuropsychological testing (please include a report with the student's permission)	
Psycho-educational testing (please include a report with the student's permission)	
Educational testing (please include a report with the student's permission)	
Other:	

V. Functional Limitations/Impact on Daily Life Activities

1. What major life activities are affected because of the student's psychological condition? Indicate the level of limitation for each.

Area of Limitation	No Impact	Moderate Impact	Substantial Impact	Don't know	Area of Limitation	No Impact	Moderate Impact	Substantial Impact	Don't Know
Learning					Speaking				
Memory					Thinking				
Concentration					Reading				
Writing					Eating				
Social Interaction					Managing Deadlines				
Self-Care					Sleeping				
Managing Internal Distractions					Managing Internal Distractions				
Communicating					Test Taking				
Stress Management					Organization				
Regular Class Attendance					Other (indicate below):				

2. Describe how current symptoms impact the student's ability to participate in academic or fieldwork (practicum/internship) experiences.

_____

_____

_____

_____

VI. Recommended Accommodations

Recommendation for academic and fieldwork (practicum/internship) accommodations: Please include justification for each accommodation.

Recommended Accommodations	Justification

VII. Certifying Professional (all the following must be filled out completely)

(Please attach your business card)

Print name/Credentials _____

Signature _____ Date _____

License number _____

Address _____

Telephone _____

For Office Use	Date Received:	_____/_____/_____	Staff Initials:	

2023/11