Accessibility Resource Center Psychiatric Disability Assessment Form

The University of Wisconsin-Milwaukee Accessibility Resource Center provides academic services and accommodations for students with disabilities. Students are required to provide documentation that verifies that a diagnosed condition meets the legal definition of a disability covered under Section 504 of the Rehabilitation Act (1973) and the Americans with Disabilities Amended Act (2008). These laws define a disability as a physical or mental impairment that substantially limits one or more major life activities. Eligibility for academic accommodations is based on documentation that clearly demonstrates a student has one or more functional limitations in an academic setting, and that one or more accommodations is needed to achieve equal access. See more information about ARC Disability Documentation Guidelines on our website.

TO BE COMPLETED BY PHYSICIAN OR MEDICAL PROFESSIONAL ONLY

A client of yours has requested disability-related accommodations with services. As this client's treating clinician/specialist, you are asked to provide the following information to allow the university to consider this client's service request(s).

Please complete the following:

1. Student Information:	
Client Name:	
Preferred Name:	
Date of Birth (mm/dd/yyyy):	

2. Diagnosis: What is the DSM-IV-R or DSM 5 Diagnosis? (Please include all if multiple.)
Are there any diagnoses that need to be ruled out?

3. Date of Diagnosis:
4. Date of First Contact with Client:
5. Date of Last Contact with Client:

6. In addition to applying DSM-IV-R diagnostic criteria, what other information did you collect to arrive at your diagnosis?

☐ Behavioral observations
☐ Developmental history
☐ Rating scale (e.g., Beck Depression Scale, etc.)
☐ Medical History
☐ Structured or unstructured clinical interview with the student
☐ Interviews with others (parents, teachers, spouse or significant others)
☐ Neuropsychological, psycho educational testing, etc. **Date(s) of testing:** _____

7. Has this student been hospitalized or received in-patient care for their disorder in the past?
☐ Yes ☐ No
If yes, what has been the frequency and typical duration of these treatments?

8. Is the student currently receiving psychotherapy? ☐ Yes ☐ No
If yes, how often?

9. What medication(s) is the student currently taking for this condition? (Name and dosage)

Are there any significant limitations to the student's functioning directly related to the prescribed medications (if known)?

10. If you are the prescribing clinician, is the student compliant with the use of medications and treatment? ☐ Yes ☐ No; please explain:

FUNCTIONAL IMPACT ASSESSMENT (REQUIRED) – Part A
11A. What methods were utilized to assess functional limitation? Please list or attach a separate page.

FUNCTIONAL IMPACT ASSESSMENT (REQUIRED) – Part B

11B. Please rate the frequency/duration and severity (using an "x") of the condition's impact on major daily life activities to the best of your knowledge. For comparison purposes, please use same age peers in a postsecondary setting.

Major Life Activity	Frequency/Duration 0-4 Scale 0=never, 1=rarely, 2=intermittent, 3=daily/frequent, 4=chronic	Unknown/ N/A	Mild	Moderate	Severe
Initiating Activities					
Concentration					
Following Directions					
Memorization					
Persistence					
Processing Speed					
Organizational Skills					
Sustained Reading					
Sustained Writing					
Problem Solving					
Listening					
Sitting					
Speaking					
Interacting with Others					
Sleeping					
Other: Please Specify					
Other: Please Specify					

SYMPTOM ASSESSMENT (REQUIRED)

12. Please rate the frequency/duration and severity (using "x") of the symptoms as related to the disability.

Symptom	**Frequency/Duration** 0-4 Scale 0=never, 1=rarely 2=intermittent, 3=daily/4=frequently, 5=chronic	**Unknown/ N/A**	**Mild**	**Moderate**	**Severe**
Compulsive Behaviors					
Delusions					
Depressed Mood					
Disordered Eating					
Fatigue/Loss of Energy					
Hallucinations					
Impulsive Behaviors					
Mania					
Obsessive Thoughts					
Panic Attacks					
Phobia (Specify)					
Physiological Symptoms:					
☐ Dizziness					
☐ Fainting					
☐ Racing Heart					
☐ Migraines/Head Aches					
☐ Nausea					
☐ Chest Pain					
☐ Shortness of Breath					
☐Other					
☐Other					
Racing Thoughts					
Self Injurious Behavior					
Suicidal Ideation					
Suicide Attempts					
Unable to Leave the House					
Other:					

13. Please list your recommendations for accommodations within the academic environment. (See a listing of common accommodations on the ARC website.) Please provide an explanation or rational for the recommendation. If available in a separate report, please attach that report.

Accommodation Recommendation	Rationale

15. Certifier Information:

Clinician Name (Print):	
Clinician Name (Signature):	
Medical Specialty:	
License #:	
Address:	
Phone:	
Email:	
Date of this Report:	

Please send this completed form and any additional documentation to:

Accessibility Resource Center
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Mitchell Hall, Room 112
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Milwaukee, WI 53211
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If you have questions, please feel free to contact our office at 414-229-6287. Thank you.