# Student Accessibility and Support Services

Directions for completing this form:
1. Download and save the form to your computer
2. Complete the fillable form
3. Submit the form by clicking the "email to SASS" button, or return via email or mail.

**Psychiatric/Psychological Disability Documentation Form**

Student's Name: _____

The student named above is applying for disability accommodations and / or services through the Student Accessibility and Support Services Office (SASS) at Rider University. In order to determine eligibility, a qualified professional must certify that the student has a psychological diagnosis and must provide evidence that it represents a substantial limitation to a major life activity. It is important to understand that documentation of this diagnosis must provide evidence that it represents a substantial impediment to a major life activity. This documentation form was developed as an alternative to traditional diagnostic reports. If a traditional diagnostic report is being submitted as documentation instead of this form, please refer to the SASS website (www.rider.edu/sass) in order to view documentation guidelines. SASS expects the following in regards to this documentation form:

- The form will be completed with as much detail as possible as partially completed form or limited responses will hinder the eligibility process.
- Assessment information that is more than a year old may be considered out of date depending on such factors as the student's current age, student's age at time of assessment and the nature of the diagnosis.
- The form is being completed by a professional who has comprehensive training and direct experience in the differential diagnosis such as a psychologist, psychiatrist, or certified social worker.
- The professional completing the form is not a family member of the student or someone who has a personal or business relationship with the student.

What is the DSM-V diagnosis for this student?

What is the severity of the condition? ◯ Mild ◯ Moderate ◯ Severe

How long has the student had this diagnosis/condition?

Explain the severity indicated above:

What is the expected duration? ◯ Chronic ◯ Episodic ◯ Short-term

Explain the duration indicated above:

Has the student ever been hospitalized for psychological reasons? ◯ Yes ◯ No

If yes, please explain:

Date of first contact with student: _____

Date of last contact with student: _____

Date(s) current psychological assessment completed: _____

Frequency of appointments with student (e.g., once a week, twice a month):

_____

**Psychological History**: Provide pertinent psychological history (include any psychological reports or testing utilized, if applicable):

**Pharmacological History:** Provide pertinent pharmacological history, including an explanation of the extent to which the medication has mitigated the symptoms of the disorder in the past:

**Psychosocial History:** Provide pertinent information obtained from the student/ parent(s)/guardian(s) regarding the student's psychosocial history (e.g., history of not sustaining relationships, history of employment difficulties, history of educational difficulties, social inappropriateness, history of risk-taking or dangerous activities, etc.):

Student's Current Symptoms and Concerns:

Explain how the symptoms related to the student's disorder cause **significant impairment** in a **major life activity** (e.g., learning, eating, walking, interacting with others, etc.) in a classroom setting, if applicable.

Please complete the following table by placing an "X" on the impact that the student's condition has on the particular activity of behavior.

| Activity | No Limitation | Moderate Limitation | Substantial Limitation | Don't Know |
|---|---|---|---|---|
| Attention to detail / accuracy of work | | | | |
| Sustaining attention | | | | |
| Listening comprehension | | | | |
| Completing tasks independently | | | | |
| Sustained mental effort | | | | |
| Organization | | | | |
| Distractibility | | | | |
| Memory | | | | |
| Restlessness | | | | |
| Impulsiveness | | | | |
| Time management | | | | |
| Mathematics | | | | |
| Reading | | | | |
| Writing | | | | |
| Other (please specify) | | | | |

Provide information regarding the symptoms that cause impairment in **two or more settings** (e.g., work, home, or school etc.), if applicable.

List the student's current medication(s), dosage, frequency, and adverse side effects.

Are there significant limitations to the student's functioning directly related to the prescribed medications? If yes, explain:

Provide an explanation of the extent to which the medication currently mitigates the symptoms of the disorder.

State the student's functional limitations from the disorder specifically in a classroom or educational setting:

State specific recommendations regarding academic adjustments, aids, and/or services for this student and the reason these accommodations are warranted based upon the student's functional limitations.

If current treatments (e.g., medications, counseling) are successful, state the reasons the above academic adjustments, auxiliary aids, and/or services are necessary?

Certifying Professional

| | |
|---|---|
| Name and Title | License or Certification # |
| Address | Phone # |
| City, State, Zip | Fax # |
| Signature of Certifying Professional | Date |

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**Email to SASS**