

## Documentation for Psychological Disorders

Kennesaw State University’s Student Disability Services provides support services and accommodations for students with documented disabilities. The treating or diagnosing healthcare professional should complete this form. Student Disability Services will use this form to evaluate eligibility for academic accommodations, which includes 1) disability diagnosis as defined under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990, as amended (ADAAA); 2) aid in the determination of appropriate services and accommodations in the academic environment.

The information provided by the health care professional will not become part of the student’s educational records, but will remain in the student’s confidential file in Disability Services. Upon request, this form may be released only to the student. In addition to the requested information, please attach any other information you think would be relevant to the student’s academic adjustment.

Please complete this form, fill out the Healthcare Provider Information section on the last page, sign it, then return it to the student, who will give it to the Disability Services Provider at Kennesaw State University.

\_\_\_\_\_   
 Date of Birth

\_\_\_\_\_   
 Print Name

\_\_\_\_\_   
 Student ID#

**Primary Diagnosis:** \_\_\_\_\_

**DSM/ICD Code:** \_\_\_\_\_ **Date of onset:** \_\_\_\_\_

**Additional Diagnosis:** \_\_\_\_\_

**DSM/ICD Code:** \_\_\_\_\_ **Date of onset:** \_\_\_\_\_

**Date of last visit:** \_\_\_\_\_ **Frequency of office visits:** \_\_\_\_\_

Describe the history, current symptoms and severity of the condition.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe the functional limitations, which affect this student in the academic setting, and give suggestions for accommodations.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List current medications, relevant side effects, and explain how each affects the individual's limitations.

<u>Medication/Dosage</u>	<u>Side Effects</u>	<u>Impact on Limitations</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe the expected progression, duration, and stability of the condition(s). Add pages if needed.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Healthcare Provider Information (In the space provided, please attach a business card.)**

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Please print)*

\*\*Provider name: \_\_\_\_\_ Title: \_\_\_\_\_ License #: \_\_\_\_\_

Attach Business Card Here