Psychiatric/Psychological Disabilities Documentation Form

Disability Services
Pellissippi State Community College 10915 Hardin Valley Road, P.O. Box 22990
Knoxville, TN 37933-0991
Phone: 865.694.6411
Fax: 865.539.7699

PLEASE REVIEW CAREFULLY AND COMPLETE ALL INFORMATION

The individual named below has applied for services from Disability Services (DS) at Pellissippi State Community College. Pellissippi State provides academic services and accommodations to individuals with disabilities. Individuals seeking services must provide appropriate documentation of their condition(s) so that DS can: a) determine eligibility for accommodations, and b) if eligible, determine appropriate accommodations.

The Americans with Disabilities Act (ADA) defines disability as "a physical or mental impairment that substantially limits one or more major life activities, a record of such impairment, or being regarded as having such an impairment. " Disabilities involve substantial limitations and are distinct from common conditions not substantially limiting major life activities.

Documentation required to verify the condition, severity, and functional limitations includes completion of this form or provision of equivalent information to DS by a licensed mental health professional. Depending on the condition, the appropriate professional should be a licensed psychiatrist, psychologist, neurophysiologist, or other qualified and license4 mental health professional. Professionals completing this form must have first-hand knowledge of the condition, experience in working with persons with psychiatric or psychological conditions and ideally a familiarity with the physical, emotional and cognitive demands experienced by students and employees in an academic setting. Diagnoses of disabilities documented by family members are unacceptable.

“The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. ‘Genetic information’ as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.”

Please complete all information.

Client Information

Client's name (Last, first; middle initial):
Client's date of birth:

Client's Pellissippi State ID (P) number:

Certifying Professional's Information

Certifying Professional's printed name:

Credentials/Specialization:

License Type:

License#:

State that issued licensure:

Mailing Address:

City/State/Zip:

Phone:

Fax:

Email address:

Please attach business card to this page or, if submitting electronically, denote your office web address.

Office web address:

Diagnosis/Diagnoses

Please include DSM Codes and name of condition(s) below:

Conditions with DSM Code:

Date of onset:

Date of diagnosis:

Diagnostic Tools

Client interview(s) ☐
Behavioral observations ☐
Medical history ☐
Psycho-educational testing ☐
Interviews with other persons ☐
Developmental history ☐
Neuro-psychological testing ☐
Self-rated or interviewer rated scales ☐
Other

Prognosis:

Expected Duration of Primary Condition: (Mark One)

Permanent ☐ Temporary ☐

Characteristics of Limiting Condition(s): (Mark All That Apply)

Stable ☐ Episodic ☐ Slow Progression ☐ Rapid Progression ☐ Improving ☐

Additional comments/information:

Medication, Treatment, and Prescribed Aids

Please list medication(s) currently being prescribed to address the diagnosis/diagnoses above.

Thoroughly describe the impact of medication side-effects that may adversely affect the client'sacademic or workplace performance.

What neducatuibm treatment and prescribed aids (i.e. counseling, therapy, support groups) are currently being used to address the diagnosis/diagnoses above?

Is the client compliant with medication and prescribed aids as part of the treatment plan?

yes ☐ no ☐

If no, please explain:

Date of last appointment:

How often does your client receive treatment?

Weekly ☐ Monthly ☐ Annually ☐ As Needed ☐

Implications for Academic/Student Life

For each major life activity listed below please mark the severity of the impact in the college setting and list specific recommendations to address each of the impacted major life activities.

Major Life Activity: Concentration

Severity of impact: None ☐ Moderate ☐ Substantial ☐ Unsure ☐

Recommendations for Accommodations/Services:

Major Life Activity: Long Term Memory

Severity of impact: None☐ Moderate☐ Substantial ☐ Unsure☐

Recommendations for Accommodations/Services:

Major Life Activity: Short Term Memory

Severity of impact: None☐ Moderate☐ Substantial ☐ Unsure☐

Recommendations for Accommodations/Services:

Major Life Activity: Information Processing

Severity of impact: None☐ Moderate☐ Substantial ☐ Unsure☐

Recommendations for Accommodations/Services:

Major Life Activity: Sleeping

Severity of impact: None☐ Moderate☐ Substantial ☐ Unsure☐

Recommendations for Accommodations/Services:

Major Life Activity: Eating

Severity of impact: None☐ Moderate☐ Substantial ☐ Unsure☐

Recommendations for Accommodations/Services:

Major Life Activity: Social Interactions

Severity of impact: None☐ Moderate☐ Substantial ☐ Unsure☐

Recommendations for Accommodations/Services:

Major Life Activity: Self-Care

Severity of impact: None☐ Moderate☐ Substantial ☐ Unsure☐

Recommendations for Accommodations/Services:

Major Life Activity: Managing Internal Distractions

Severity of impact: None☐ Moderate☐ Substantial ☐ Unsure☐

Recommendations for Accommodations/Services:

Major Life Activity: Managing External Distractions

Severity of impact: None☐ Moderate☐ Substantial ☐ Unsure☐

Recommendations for Accommodations/Services:

Major Life Activity: Time Management

Severity of impact: None ☐ Moderate ☐ Substantial ☐ Unsure ☐

Recommendations for Accommodations/Services:

Major Life Activity: Motivation

Severity of impact: None ☐ Moderate ☐ Substantial ☐ Unsure ☐

Recommendations for Accommodations/Services:

Major Life Activity: Stress Management

Severity of impact: None ☐ Moderate ☐ Substantial ☐ Unsure ☐

Recommendations for Accommodations/Services:

Major Life Activity: Organization

Severity of impact: None ☐ Moderate ☐ Substantial ☐ Unsure ☐

Recommendations for Accommodations/Services:

Major Life Activity: Other (Please specify)

Severity of impact: None ☐ Moderate ☐ Substantial ☐ Unsure ☐

Recommendations for Accommodations/Services:

Certifying Information

Please print this document, sign and date below. You may fax or send this form to the contact information on page one.

Date:

Certifying Professional's Signature:

Signature denotes content accuracy, adherence to professional standards and guidelines on page one of this document. The student is responsible for any costs associated with completing this form.