



## University Documentation Guidelines for Psychological Disabilities

\_\_\_\_\_ has recently requested accommodations from Student Disability Services on the basis of a psychological disability. By our current definition, a psychological disability is coded on DMS IV Axis I or II as moderate to severe, has a Global Assessment of Functioning (GAF) score of 60 or below, and interferes with major life functions. To qualify for services we will need verification now and each 12 months for which services are requested. As your name has been provided as the diagnosing professional, you are requested to complete all sections of this form. A signed release statement is enclosed.

Please return the completed form to the address below. Thank you for your prompt reply so we can begin considering services as soon as possible.

Michele Atterson  
Director of Student Disability Services

I. DSM IV

Axis I: \_\_\_\_\_  
Code \_\_\_\_\_

Axis II: \_\_\_\_\_  
Code \_\_\_\_\_

Axis III: \_\_\_\_\_

Axis IV: \_\_\_\_\_

Axis V: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

How often to you regularly meet with this student? \_\_\_\_\_

II. Does this condition interfere with one of the following major life activities?

\_\_\_\_\_ walking      \_\_\_\_\_ hearing      \_\_\_\_\_ seeing

\_\_\_\_\_ working      \_\_\_\_\_ learning      \_\_\_\_\_ performing manual tasks

(Over)

III. Describe the functional limitations and/or behavioral manifestations (e.g., easily distracted, poor concentration, difficulty focusing for extended period of time, difficulty formulating and executing plan of action, difficulty overcoming unexpected obstacles, panics in unfamiliar surroundings and situations, etc.) and recommendations you have prescribed:

Behavior:

Recommendations:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

III. List any medications prescribed and side effects being experienced:

\_\_\_\_\_  
\_\_\_\_\_

IV. Describe information you have concerning this student's intellectual strengths and weaknesses:

\_\_\_\_\_  
\_\_\_\_\_

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**CERTIFYING LICENSED PHYSICIAN, PSYCHIATRIST, OR CLINICAL  
PSYCHOLOGIST LICENSE # \_\_\_\_\_**

\_\_\_\_\_  
Name Typed or Printed

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Date

**Available in alternative format upon request.**

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*Guidelines for Documenting Psychological Disabilities  
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136 Jordan Hall, 4600 Sunset Avenue, Indianapolis, IN 46208-3485  
Voice/TTY: (317) 940-6379 · Fax: (317) 940-9036