DISABILITY VERIFICATION FORM PSYCHIATRIC, ADD/ADHD,TBI

The diagnosing professional must be a physician or other medical specialist with experience and expertise in the area related to the student's disability. Form can be handwritten but please be clear and neat.

Student Name: _____

Student Number: _____

☐ Psychiatric ☐ Attention deficit ☐ Hyperactivity disorder ☐ Traumatic Brain Injury

Please list all DSM-V or ICD Diagnosis (text)

	Date diagnosed			Date of last clinical contact			Current Severity
1.							
	Day	Month	Year	Day	Month	Year	
2.	Date diagnosed			Date of last clinical contact			Current Severity
	Day	Month	Year	Day	Month	Year	
3.	Date diagnosed			Date of last clinical contact			Current Severity
	Day	Month	Year	Day	Month	Year	

EVALUATION

Date of last evaluation _____

How did you get at this diagnose? Please check all relevant items below, add brief notes that you understand will help to determine eligibility for accommodations. (Specify dates of test's given)

☐ Structured or unstructured interviews with student ☐ Behavioral observations

☐ Interview with other person (parent, teacher, therapist) ☐ Neuropsychological test (Attach copy document)

☐ Medical evaluation ☐ MRI

☐ Psychoeducational test (Attach copy document) ☐ Other specify _____

Evaluation notes _____

Functional limitations: Yes ☐ No ☐ Describe if yes: _____

Please describe in detail any functional limitations that fall into the significant range. _____

Please list current medications and treatment history. Medication management ☐ Physical/Occupational therapy ☐

Medication side effects: _____

Coexisting conditions: (provide details about any coexisting medical or psychiatric conditions, please include relevant reports)

Past accommodations: Yes ☐ No ☐ (please describe if yes)

Suggested accommodations: (please list specific academic accommodations you suggest based on your assessment of student clinical and academic history and diagnosis)

Severity of symptoms: Mild ☐ Moderate ☐ Severe ☐

Prognosis of disorder: Mild ☐ Moderate ☐ Severe ☐

The prognosis for the medical condition or disability above is:

☐ Permanent/Chronic ☐ Long term: 6/12 months

☐ Short term/Temporary: 6 months or less Expected duration:

☐ Episodic (please describe below)

Please provide any additional information you feel useful in determining the nature and severity of the student's disability and (2) why each recommended accommodation is needed. Your recommendation should not be supported solely by a history of prior accommodation. You can prepare a narrative in a separate sheet of paper.

Examiner's Name and Title

Signature

License/Certification Number

Date