Indiana University Southeast Office of Disability Services

Psychiatric Disability Verification Form

(To be completed before each semester in which a student wishes to use accommodations)

Student Information

Name: ____

Indiana University Southeast student ID: ___________________

Provider Information

(Please sign and complete fully)

Provider Name (print): ____

Title: ____

License or Certification #: ____

Address: ____

Phone: (_____) ______________________ Fax: (____) _________________________

DIAGNOSTIC INFORMATION

Please provide responses to the following items by typing or writing clearly. Illegible forms will delay the documentation review process for the student.

1. Date of Diagnosis: ____

2. Date student was last seen: ____

3. DSM-IV Diagnosis

a. Axis I: ____

b. Axis II: ____

c. Axis III: ____

d. Axis IV: ____

e. Axis V (GAF Score): ____

4. What is the severity of the condition? Please check one:

☐ mild ☐ moderate ☐ severe

6. What is the expected duration of this disability?

____

____

____

____

7. Major Life Activities

Please check which of the following major life activities listed above are affected because of the impairment and indicate severity of limitations.

Life Activity	Negligible	Moderate	Substantial	Don't Know
Concentrating				
Memory				
Eating				
Social Interactions				
Self Care				
Regular Attendance				
Keeping Appointments				

Stress Management				
Managing internal distractions				
Managing external distractions				
Sleeping				
Organization				

8. What specific symptoms does the student have that might affect the student's academic performance?

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____
____
____
____
____
____

10. Describe any situations or environmental conditions that might lead to an exacerbation of the condition.

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11. Is the student currently receiving therapy or counseling?

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____

12. What medications is the student currently taking? If so, how might side effects, if any, affect the student's academic performance?

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13. Please state specific recommendations regarding academic accommodations for this student, and a rationale as to why these accommodations/adjustments/services are warranted based upon the student's functional limitations. Indicate why the accommodations are necessary.

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Provider Signature: __________________________________ Date: ______________

All documentation is confidential