DOCUMENTATION OF PSYCHOLOGICAL CONDITION

The student named below has applied for services from the Accessibility Resource Office (ARO) at Westmont College. In order for the ARO to determine eligibility for services, we will need your assessment and diagnosis of this student.

Please note: All information that you provide may be shared with the student. This information is kept confidential, and cannot be released without written consent from the student.

Student Name: ______________________________Today's date ______________________

Certifying professional (please print): _________________________Title ______________

City________________________________ State ____________ Zip _________________

License No. __________________Phone____________________Fax____________________

I. DSM-5 Diagnosis

Please include all relevant diagnostic information including subtypes and/or specifiers for diagnostic domains & subgroups (as indicated in DSM-V) including V/Z codes: psychosocial and environmental stressors.

Focus of Clinical Treatment	Please provide all pertinent ICD-10-CM diagnoses
Medical Conditions	

Please specify current severity (please severity with an X):

0--50---100 Mild

Moderate Severe

II. Treatment

Please provide a brief summary of the diagnostic interview(s). This should include the chief complaint, history of presenting symptoms and past functioning, duration and severity of the disorder, and relevant, developmental, historical and familial data.

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____
____

Background

Number of sessions with student: ________________

Date you first saw the student? __________________

How often do you provide treatment? ____

When did you last evaluate this student: ____

Please list other providers the student is in treatment with:

____

Frequency of treatment with other providers: ___________________________________

Is the student currently a danger to self or others (Explain)?

____

The student's condition is: __Stable __Improving __Worsening __Cyclically variable

Prognosis: __Poor __Guarded __Fair __Good __Excellent

Prescribed Medication & Dosages:

Is the student currently being prescribed medications? ____Yes ____No

Please list medications the student is currently taking:

____

____

____

Is the student compliant with medications? ____Yes ____No

If no, explain: ____

How long has student been on current medications? ______________________________

Does the medication mitigate the student's symptoms?

___Completely ____Partially ____Not mitigated

III. Impact on Major Life Activities

Which, if any, of the other major life activities below, does the impairment(s) affect?

PHYSICAL IMPACTS	Unknown	No Impact	Minimal Impact	Moderate Impact	Severe Impact
Breathing					
Caring for self					
Hearing					
Learning					
Performing manual tasks					
Seeing					
Speaking					
Working					
Walking					
Other, please specify: ______________________ ______________________					
LEARNING IMPACTS					
Engagement					

Attending					
Concentrating					
Thinking					
Writing					
Avoidance, please specify: ________________________________					
Cognitive processing					
Long term memory					
Short term memory					
Effect of anxiety on cognitive functioning					
Distractibility					
Reading					
Accessing prior knowledge					
Exploration					
Decision-making					
Investigating					
Organizing					
Performing					
Planning					
Problem solving					
Time management					
Explanation					
Analyzing					
Reasoning					
Supporting with evidence					
Participating in class discussions					
Giving oral presentations/group projects					
Expanding understanding					
Processing speed					
BEHAVIORAL/INTERPERSONAL IMPACT					
Restricted or labile affect in daily social activity					
Excessive activity level					
Impulsivity					

Fatigue or low energy					
Frequent emotional outbursts					
Irritability/agitation					
Restlessness					
Interpersonal fears or suspiciousness					
Preoccupation with self					
Rambling, pressured speech					
Changes in appetite					
Avoidance of social interactions					
Attending class					
Changes in sleeping, please specify: ________________________________					
Initiation work					
Suicidal ideation ___Active ___Passive					
Motivation					
Difficulty initiating interpersonal conduct					
Other, please specify: ________________________________ ________________________________					
PERCEPTUAL IMPACTS					
Visual hallucinations					
Auditory hallucinations					
Other, please specify: ________________________________ ________________________________					
MEDICATION SIDE EFFECTS					
Drowsiness					
Blurred vision					
Restlessness					
Fatigue					
Confusion					
Thirst					
Memory loss					

Anxiety					
Other, please specify: ___________________________________ ___________________________________					

IV. Assessing Functional Limitations

What methods were used to determine the impact on major life activities?

___Structured or Unstructured interviews with the student.

___Interviews with other persons.

___Behavioral Observations.

___Developmental History

___Educational History

___Medical History

___Neuro-psychological testing (Please attach results)

Dates of testing: _________________________

___Psycho-Educational Testing (Please attach results)

Dates of Testing: _________________________

___Standardized or non-standardized rating scales

___Other (Please Specify): _______________________

V. Additional Information

Please provide any additional information below, including information related to how the disability symptoms impact various academic tasks (e.g. examination process, focus in lectures, time management, organization, and completion of long-term projects). Please include any recommendations for accommodations.

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____
____

Signature ____ Date__________________________

Return to:

Westmont College

The Accessibility Resource Office

955 La Paz Rd., Santa Barbara, CA 93108

FAX to: 805-565-7244

EMAIL/SCAN to: aro@westmont.edu