

TO:

FROM:

Webster University

RE: Criteria For Documenting Psychiatric Disabilities

The following student, _____ (DOB _____), has applied for services available to qualified individuals with disabilities through Webster University. Current and comprehensive documentation of the student's disability must be on file with Webster University in order to determine appropriate and reasonable accommodations. The student has indicated that you could provide this documentation, along with information pertinent to the kinds of accommodations the student may need to function successfully in a college environment. We ask, therefore that you address the criteria outlined below on professional letterhead or complete the attached verification form. A signed release of information form is enclosed.

~~CRITERIA FOR DOCUMENTING PSYCHIATRIC DISABILITIES~~

1. A clear statement of the DSM-IV diagnosis, including pertinent history
2. A description of present symptoms, fluctuating conditions/symptoms, and prognosis.
3. Current documentation (age of recency requirement dependent upon the disabling condition)
4. A summary of assessment procedures used to make the diagnosis.
5. Medical information to be considered in a college environment, including medication needs.
6. Suggestions of reasonable accommodations (should be supported by the diagnosis).

WEBSTER UNIVERSITY DISABILITY VERIFICATION FORM
STUDENTS WITH PSYCHIATRIC DISABILITIES

STUDENT NAME: _____ DATE: _____

SOCIAL SECURITY NUMBER: _____ I.D. #: _____

DIAGNOSTIC INFORMATION

DSM IV diagnosis: _____

Pertinent History: _____

Onset of current diagnosed disability: _____

Summary of present symptoms: _____

Assessment procedures and evaluation instruments used: _____

Prognosis: _____

Is the disability currently stabilized: _____ Please describe: _____

MEDICATION/TREATMENT INFORMATION

Describe current medication needs and side effects and how the medication will affect the student's educational performance: _____

How long has the student been taking this medication? _____

Is the student still adjusting to or stabilized on the medication? _____

Is the student compliant with medication regime as prescribed? _____

Does the student need to take medication during class hours? _____ If yes, please explain.

INFORMATION SUPPORTING ACCOMMODATION REQUESTS

Describe the student's functional limitations in an educational setting: _____

Are there crisis episodes associated with the disability? _____

Please describe any mobility issues/concerns associated with the student's disability. _____

Describe any restrictions: _____

Will the disability affect the student's class attendance? If yes, please explain. _____

How will the disability affect the student's class participation (attending lectures, doing research, writing papers, reading large amounts of information, meeting deadlines, working in small and large groups, ect.)? _____

Have you any recommendations to make regarding effective academic accommodations to equalize this student's educational opportunities at the post-secondary level? (Describe services/accommodations in exam administration, classroom or study activities, or course requirements). _____

CERTIFYING AUTHORITY

SIGNATURE: _____

PRINT NAME AND TITLE: _____

ADDRESS: _____

PHONE: _____ **FAX:** _____ **DATE:** _____

**Please accompany this form with a note on your professional letterhead
describing how long and under what conditions you have treated this patient.**