THE UNIVERSITY OF CHICAGO

Campus & Student Life
Student Disability Services

5501 South Ellis Avenue, Chicago, IL 60637 • 773.702.6000 • disabilities.uchicago.edu

Disability Documentation Form

This form is to be completed by a certified health professional who has evaluated or is treating a UChicago student for psychological or neurodevelopmental disorders defined within the Diagnostic and Statistical Manual of Mental Health Disorders (DSM 5) such as Generalized Anxiety Disorder, Attention Deficit/Hyperactivity Disorder (ADHD), Major Depressive Disorder, Obsessive Compulsive Disorder, Post-Traumatic Stress Disorder (PTSD), and Autism Spectrum Disorder. The purpose of the form is to determine eligibility for disability services and accommodations at the University of Chicago.

Student Disability Services (SDS) provides services and accommodations to persons with disabilities to ensure **equal access and opportunity to educational programs and activities**. Current disability documentation is used to verify that a diagnosed condition meets the legal definition of a disability covered under Section 504 of the Rehabilitation Act (1973) and the Americans with Disabilities Act as amended in 2008. These laws define a disability as a physical or mental impairment that substantially limits one or more major life activities. Eligibility for disability services is based, in part, on documentation that clearly demonstrates that the student has one or more functional limitations. An SDS Director meets with each student to discuss their access needs and requests. It is our goal to ensure equal access to our programs and services.

Disability documentation must include the following elements:

A. Credentials of the evaluator
B. Current statement of diagnosis
C. Comprehensive evaluation, including:
    a. Description of diagnostic methodology
    b. Relevant history
    c. Assessment of functional limitations
    d. Treatment/medication and prognosis
    e. Accommodation recommendations based on addressing areas of impairment.

Please review our detailed documentation guidelines for mental health disabilities on our website (https://disabilities.uchicago.edu/students/psychological-disability-accommodations/).

Student Consent

I, _____, authorize my health-care provider above to release to Student Disability Services the medical information requested on this form for the purpose of determining appropriate accommodation for my disability while a student at the University of Chicago.

Signature of student: _____ Date: _____

If signed by person other than patient, state relationship and authority to do so:

_____

Expiration Date: _____

Student Information

Student Name: _____

Certifier Information

Clinician Name: _____

Clinician Signature: _____

Medical Specialty: _____

License/Certification #: _____ City & State: _____

Email Address: _____

Phone: _____

Website (if applicable): _____

Please complete the following: Today's Date: _____

Diagnosis

Name of the DSM-5 diagnosis (or ICD-10 code): _____

Are there any pending diagnoses?

Date of diagnosis: _____ Date of first contact with client: _____

Date of last contact: _____ Frequency of contact: _____

Consultation with other medical or mental health professional:

Name:_____ Date:_____

In addition to the DSM diagnostic criteria, what other information did you collect to arrive at your diagnosis?

- ☐ Behavioral observations
- ☐ Developmental history
- ☐ Rating scales (e.g., Beck Depression Scale, etc.)
- ☐ Medical history
- ☐ Structured or unstructured clinical interview with the student
- ☐ Interviews with others (parents, teachers, spouse or significant others)
- ☐ Neuropsychological, psychoeducational testing, etc.
  (Dates of testing: _____)

What methods or tools were utilized to assess functional limitation? Please list (or attach under separate cover).

History

Is the student currently receiving psychotherapy?

☐ Yes ☐ No

If yes, how often? _____

Is the student current taking medications?

☐ Yes ☐ No ☐ N/A – not prescribing physician

If yes, describe the impact of the medication on the student's ability to participate in the educational process (whether the impact is negative or mitigating):

Has the student been hospitalized or received in-patient care for this/these disorder(s) in the past?

☐ Yes ☐ No

If yes, what are the dates of these treatments? _____

Is there evidence of previous treatment by a health care professional?

☐ Yes ☐ No

If yes, please explain:_____

Describe how the student is substantially limited by the symptoms (refer to the next pages for a list):

Symptom Assessment List

Please rate the frequency/duration and severity (using "x") of the **relevant** symptoms as related to the disability.

Frequency: How frequently do limitations occur?
0=never, **1**=rarely, **2**=intermittently, **3**=frequently

Duration: How long has the student experienced these limitations?
1=more than 1 year, **2**=months, **3**=recent acute onset

Mental Health Symptoms	Frequency Scale 0-3 (see scale above)	Duration Scale 1-3 (see scale above)	Severity			Comments (Use back of form if more space is needed)
			Mild	Moderate	Severe	
Compulsive Behaviors						
Impulsive Behaviors						
Obsessive Thoughts						
Depressed Mood						
Disordered Eating						
Fatigue/Loss of Energy						
Hypomania						
Racing Thoughts						
Self-Injurious Behavior						
Suicidal Ideation						
Panic Attacks						
Phobia - please specify:						
Anxious Mood						
Unable to Leave Residence						
Delusions						
Hallucinations						
Other, please specify: _____						

Symptom Assessment List (continued)

Please rate the frequency/duration and severity (using "x") of the **relevant** symptoms as related to the disability.

Frequency: How frequently do limitations occur?
0=never, **1**=rarely, **2**=intermittently, **3**=frequently

Duration: How long has the student experienced these limitations?
1=more than 1 year, **2**=months, **3**=recent acute onset

Physiological Symptoms	Frequency Scale 0-3 (see scale above)	Duration Scale 1-3 (see scale above)	Severity			Comments (Use back of form if more space is needed)
			Mild	Moderate	Severe	
Dizziness						
Fainting						
Racing Heart						
Migraines/Headaches						
Nausea						
G.I. Distress						
Shortness of Breath						
Chest Pain						
Fatigue						
Light Sensitivity						
Other, please specify: _____						
Other, please specify: _____						
Other, please specify: _____						
Other, please specify: _____						

Functional Impact Assessment: Impact in Post-Secondary Setting

Please rate the frequency/duration and severity (using "x") of the condition's impact on **relevant** major daily activities to the best of your knowledge. (For comparison purposes, please use same age peers in a postsecondary setting.)

Frequency: How frequently do limitations occur?
0=never, **1**=rarely, **2**=intermittently, **3**=frequently

Duration: How long has the student experienced these limitations?
1=more than 1 year, **2**=months, **3**=recent acute onset

Major Life Activity	Frequency Scale 0-3 (see scale above)	Duration Scale 1-3 (see scale above)	Severity			Comments (Use back of form if more space is needed)
			Mild	Moderate	Severe	
Initiating Activities						
Concentration						
Following Directions						
Memorization						
Persistence						
Processing Speed						
Organizational Skills						
Sustained Reading						
Sustained Writing						
Problem Solving						
Listening						
Sitting						
Speaking						
Interacting with Others						
Sleeping						
Self-Care						
Other: please specify: _____						
Other: please specify: _____						

Provide comments on daily life impairment experienced by student in a post-secondary setting:

Anticipated Progress and Prognosis

Progress and anticipated prognosis (if relevant, provide information stability of the condition, including details on the cyclical nature or known environmental triggers):

Additional Comments and Recommended Accommodations

(Accommodation recommendations must be based on a substantially limiting mental/physical impairment)