**Documentation of a Psychological Disability**

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In order to determine eligibility and to provide services to a Rutgers New Jersey Medical School student, we require documentation of the student's psychological disability.

Documentation assists the New Jersey Medical School and the Rutgers Office of Disability Services staff to:

* establish a student's eligibility for services
* understand the impact of a student’s condition(s) in an academic environment
* and determine strategies and reasonable accommodations to facilitate equal access.

Further information on the components of professionally prepared documentation such as: qualified professionals; diagnostic statements; diagnostic methodology; current functioning and current documentation; functional impairment; duration, progression, and stability of a condition; and documentation to support requested reasonable accommodations can be found at the following link:

https://ods.rutgers.edu/students/documentation-guidelines

In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment.

This form and the letter should be returned directly to:

**Julie Ferguson, Asst. Dean for Student Affairs**

**Rutgers New Jersey Medical School**

**185 S. Orange Ave., MSB B640**

**Newark, NJ 07103**

Alternatively, they may be faxed to: (973) 972-6930.

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Please contact us if you have questions or concerns. Thank you for your assistance.

**Student's First Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Student's Last Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Today's Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Diagnosis:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date Student was Last Seen:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Frequency of Appointments**:

* Once a week
* Twice a week
* Once a month
* Once every six months
* Once a year
* On an as needed basis

**DSM-IV Diagnoses:**

Axis I: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Axis II: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Axis III: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Axis IV: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Axis V (GAF score): Present time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Average over last year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is the expected duration of the condition?**

* Short term (Less than 6 months)
* Episodic
* Long Term (6 months-1 year)
* Chronic (longer than 1 year with frequent recurrence)

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| **Top of Form****In addition to DSM - IV criteria, how did you arrive at your diagnosis?** (Please check all relevant items below): * Structured or unstructured interviews with the person him/herself
* Interviews with other persons
* Behavioral observations
* Developmental history
* Educational history
* Medical history
* Neuropsychological testing
* Psychoeducational testing
* Standardized or un-standardized rating scales
* Other

If you selected Neuropsychological, please provide the date of the testing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If you selected Psychoeducational Testing, please provide the date of the testing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Is the student currently taking medications? * Yes
* No

If yes above, please provide information on each medication below.Medication/Dosage/Frequency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Without Medication/ Mitigation (check all that apply) :**

|  | **No Impact** | **Moderate Impact** | **Substantial Impact** | **Don't Know** |
| --- | --- | --- | --- | --- |
| Concentration |  |  |  |  |
| Memory |  |  |  |  |
| Sleep/Walking |  |  |  |  |
| Eating |  |  |  |  |
| Social Interaction |  |  |  |  |
| Self-Care |  |  |  |  |
| Managing Internal Distractions |  |  |  |  |
| Managing External Distraction |  |  |  |  |
| Complex/Abstract thinking |  |  |  |  |
| Attending class regularly and on time |  |  |  |  |
| Making and keeping appointments |  |  |  |  |
| Stress Management |  |  |  |  |
| Organization and Prioritization of task |  |  |  |  |
| Other |  |  |  |  |

**With Medication (check all that apply):**

|  | **No Impact** | **Moderate Impact** | **Substantial Impact** | **Don't Know** |
| --- | --- | --- | --- | --- |
| Concentration |  |  |  |  |
| Memory |  |  |  |  |
| Sleep/Waking |  |  |  |  |
| Eating |  |  |  |  |
| Social Interaction |  |  |  |  |
| Self-Care |  |  |  |  |
| Managing Internal Distractions |  |  |  |  |
| Managing External Distractions |  |  |  |  |
| Complex/Abstract Thinking |  |  |  |  |
| Attending Class regularly and on time |  |  |  |  |
| Making and Keeping Appointments |  |  |  |  |
| Stress Management |  |  |  |  |
| Organization and Prioritization of Tasks |  |  |  |  |
| Other |  |  |  |  |

Bottom of Form |

**Current symptoms:**

Please list the student's current symptoms, and then indicate what reasonable academic accommodations would be related to the symptom indicated.  More detailed information regarding reasonable academic accommodations can be found at: https://ods.rutgers.edu/students/reasonable-accommodations

***Example:* Symptom** "Due to the student's depression, the student has difficulty concentrating."

**Recommended Accommodation:** Due to the difficulty concentrating, the student will require extra time on tests.

Symptom 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recommended Reasonable Accommodation 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Symptom 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recommended Reasonable Accommodation 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Symptom 3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recommended Reasonable Accommodation 3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the student's prognosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long do you anticipate that the student's academic achievement will be impacted by his/her disability?

(Please select one option):

* 6 months
* 1 year
* More than 1 year

Is there anything else you think we should know about the student's psychological disability? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Role of the person completing this form (check all that apply):

* Treating Professional
* Psychotherapy
* Medication Supervision
* Other Treating Professional
* Evaluator
* 2nd Opinion Evaluator
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you related to the student?

* Yes (If yes, please specify your relationship to the student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)
* No

Provider's full name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

License number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Profession: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider's address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Provider's phone/fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider's email address : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To verify that a physician or medical provider filled out this form, we require a copy of a signed letter on your letterhead. Please attach the letter to this form.