VERIFICATION OF A PSYCHIATRIC DISABILITY

The Disability Services Office at Otterbein University provides services to students with diagnosed psychiatric disabilities. To determine eligibility for services, this office requires current and comprehensive documentation of this disorder from the diagnosing psychiatrist, psychologist, or neurologist currently treating the student.

Please answer the following questions pertaining to:  

Date: ___________________________  Student ID #: ___________________________

1. Date of diagnosis: ___________________________

2. Date student last seen: ___________________________

3. DSM-IV Diagnosis

   Axis I: ___________________________

   Axis II: ___________________________

   Axis III: ___________________________

   Axis IV: ___________________________

   Axis V: ___________________________

4. In addition to DSM-IV criteria, how did you arrive at your diagnosis?

   □ Structured or unstructured interviews with the student
   □ Interviews with other persons
   □ Behavioral observations
   □ Developmental history
   □ Educational history
   □ Medical history
   □ Neuro-pychoeducational testing. Date(s) of testing? ___________________________
   □ Psychoeducational testing. Date(s) of testing? ___________________________
   □ Standardized or un-standardized rating scales
   □ Other. (Please specify) ___________________________

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Westerville, OH 43081-2006
TEL (614) 823-1610
FAX (614) 823-1983
www.otterbein.edu
5. What is the severity of the disorder? □ Mild   
   □ Moderate   
   □ Severe   

Please explain the severity indicated above: 

__________________________________________________________________________

__________________________________________________________________________

6. What is the expected duration of this disability? 

__________________________________________________________________________

__________________________________________________________________________

7. Major Life Activities Assessment:  
Please check which of the following major life activities listed below are affected because of the impairment. Please indicate severity of limitations. 

<table>
<thead>
<tr>
<th>Life Activity</th>
<th>Negligible</th>
<th>Moderate</th>
<th>Substantial</th>
<th>Don’t know</th>
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<tbody>
<tr>
<td>Concentrating</td>
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<td>Memory</td>
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<td>Eating</td>
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<td>Social Interactions</td>
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<td>Self Care</td>
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<td>Regular Attendance</td>
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<td>Keeping Appointments</td>
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<td>Stress Management</td>
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<td>Managing Internal Distractions</td>
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<td>Sleeping</td>
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<td>Organization</td>
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</tbody>
</table>

8. Please describe the student’s symptoms relating to this diagnosis. 

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
9. What specific symptoms does the student have that might affect the student’s academic performance?

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

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

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

11. Is this student currently receiving therapy or counseling?

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

12. What medication(s) is the student currently taking? How effective is the medication at controlling the symptoms? How might the side effects, if any, affect the student’s academic performance?

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

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.

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
14. If the current treatments (i.e. Medications) are successful, state the reasons the above academic accommodations and/or auxiliary aids are necessary.

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

Signature: ___________________________       Date: ___________________________

Provider Name (printed):

Title:

License Number (if applicable)

Address:

City, State, Zip

Phone Number:

Fax Number:

Email Address:

Please return this information to:
Kera McClain Manley
Disability Services Coordinator
Otterbein University
Westerville, OH 43081

Phone: 614-823-1618
FAX: 614-823-1618