COLUMBIA HEALTH
Disability Services

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Verification of Disability Form for Mental Health Treatment Providers

Purpose: The student named below has indicated that s/he has a disability and will require reasonable accommodations to participate in a program or activity at Columbia University. The information you provide will be one of the criteria used to evaluate the student's eligibility for the requested accommodations or services. **Please take the time to complete this form in its entirety.** All information provided will be kept confidential in accordance with the Family Educational Rights and Privacy Act (FERPA).

Student Name: _____ UNI: _____

Date student was last seen: _____

Dates of treatment with current provider/facility: _____

Current Principal DSM-V Diagnosis with numerical code including specifier and subtype, if applicable:

_____ Date of Diagnosis: _____

Additional Diagnosis(es) in the order of focus of attention and treatment :

_____ Date of Diagnosis: _____

_____ Date of Diagnosis: _____

Associated Medical Condition(s), if applicable:

_____ Date of Diagnosis: _____

_____ Date of Diagnosis: _____

Current Status of each of the above condition(s) (e.g. Active, Progressing, Controlled, In Remission):

_____
_____
_____
_____

In addition to DSM-V criteria, how did you arrive at your diagnosis? Please check all that apply.

- ☐ Clinical interviews with student
- ☐ Review of medical records
- ☐ Interviews with other persons
- ☐ Review of educational records
- ☐ Behavioral observations
- ☐ Neuropsychological testing (include dates): _____
- ☐ Standardized rating scale/assessment (please specify): _____
- ☐ Other (please specify): _____

In your current clinical assessment, please indicate the degree of the student's functional limitations on most days, keeping in mind the positive and negative effects of any treatment modalities and/or their personal circumstances:

☐ **Mild** ☐ **Moderate** ☐ **Substantial** ☐ **Severe**

Be as specific and detailed as possible to what exacerbates the student's condition(s) and any relevant psychosocial and contextual factors:

_____
_____
_____
_____

Please provide details regarding the following:

1. **Student's treatment history:** _____
_____
_____
_____
_____

2. **Current treatment plan and expected duration of treatment (psychotherapy, medication, etc.):**

_____
_____
_____
_____

Please provide the following information regarding any medications related to the condition(s) that the student is currently prescribed:

Medication	Dosage	Frequency	Positive Effects	Adverse effects

Please describe the way(s) that the student's condition presents for the student and/or how the student is individually impacted:

_____
_____
_____
_____
_____
_____

What are the student's current functional limitations with respect to the following areas? Please list below:

1) Time management and organization: _____

_____
_____
_____
_____

2) Executive Functioning/ planning:_____

_____
_____
_____
_____
_____

3) Self-care or social interactions: _____

_____
_____
_____
_____
_____

4) Sleeping: _____

_____
_____
_____
_____
_____

5) Cognitive processes such as concentration, memory, rapidity of information processing, fatigability: _____

_____
_____
_____
_____
_____

6) Ability to attend or participate in class: _____

_____
_____
_____
_____
_____

7) Learning: _____

_____
_____
_____
_____
_____

8) Other: _____ -
_____
_____
_____
_____

Please provide specific recommendations regarding academic accommodations for this student, and a <u>rationale</u> as to why these accommodations/services are warranted, based upon the student's functional limitations (e.g. if a note taker is suggested, state the reasons for this request related to the student's symptoms).

Recommended accommodation: _____

Rationale: _____
_____
_____

Recommended accommodation: _____

Rationale: _____
_____
_____

Recommended accommodation: _____

Rationale: _____
_____
_____

Anticipated duration of need for accommodation: _____

Other pertinent information that would be helpful when determining accommodations for student:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please check the following that apply:

- ☐ **I am the primary person involved in the student's treatment**
- ☐ **I am a part of the student's treatment team**
- ☐ **The student is my former patient, who is currently under the care of another provider**
- ☐ **I was the original person who diagnosed this student as having a disability**

Name & Credentials of Treatment Provider: _____

License #: _____ **State:**_____

Address: _____

Telephone: _____

Signature: _____ **Date:** _____

☐ **I hereby certify that the above information is true and correct and that the information provided is objective medical/ psychological information relative to this student's application for disability accommodations.**

☐ **I am not related to the student by blood or marriage**