DISABILITY VERIFICATION OF PSYCHIATRIC DISORDERS

Student name: ______________________________ ID # ___________
Date of birth: ______________ Phone: __________________________

The following information is to be completed by:
a psychiatrist, psychologist or other licensed mental health practitioner.
The information below will be used to assist us in determining if reasonable
classroom accommodations may be needed.

Please DO NOT use this form to document learning disabilities as
a complete psychological evaluation is required

PLEASE MAKE COPIES OF THIS FORM AS NEEDED.

ONLY ONE DISABILITY DIAGNOSIS PER FORM WILL BE ACCEPTED.

• Specific diagnosis: (one per form)_____________________________________________________
• Diagnostic Code: __________________________
• Date of diagnosis: ________________________
• Level of severity: _________________________
• Is the diagnosed condition acute or chronic? ____________________________________________
• In your opinion, is this student a danger to him/herself or others? Yes _________
   No________
• If yes, please explain.________________________________________________________________________
  _______________________________________________________________________________________
  _______________________________________________________________________________________
  _______________________________________________________________________________________
  _______________________________________________________________________________________
• Date of first visit: ________ Date of last visit: __________ Frequency of visits_____________
• Projected duration of treatment:___________________________________________________________
• Please list relevant tests administered and clinical observations used to make this diagnosis:
  _______________________________________________________________________________________
  _______________________________________________________________________________________
  _______________________________________________________________________________________
  _______________________________________________________________________________________
• Please describe the symptoms which meet the criteria for the diagnosis listed above:
  _______________________________________________________________________________________
  _______________________________________________________________________________________
  _______________________________________________________________________________________
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Continued on back of this form >>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>
• Is this student taking medication that can affect attention, concentration or any other facet of learning? If yes, please list all medications and their side effects.

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<th>Medication</th>
<th>Side Effect(s)</th>
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• What are the student's functional limitations in an educational setting?

___________________________________________________________________________
___________________________________________________________________________
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• Do you have any specific recommendations for accommodations in an educational setting?

___________________________________________________________________________
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Diagnostician’s signature

Please print diagnostician’s name and title

Phone: FAX Date

Disability Services holds all medical and psychological documentation regarding college students in a confidential manner. Please complete this form quickly and FAX it back to our office. If you have any questions regarding this request, please contact our office at 954-201-7655. Thank you for your assistance.

Please reply to: Office of Disability Services
Broward College
111 East Las Olas Blvd
Fort Lauderdale, Florida 33301

FAX: 954-201-7492