UNIVERSITY OF CALIFORNIA SAN DIEGO

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SANTA BARBARA • SANTA CRUZ

OFFICE FOR STUDENTS WITH DISABILITIES
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LA JOLLA CALIFORNIA 92093-0019
WEB: http://disabilities.ucsd.edu

Documentation Form for ADD/ADHD and/or Psychological Disabilities

The student below has requested accommodations on the basis of ADD/ADHD and/or a Psychological Disability through the Office for Students with Disabilities (OSD) at UC San Diego. In order to verify the disability, its severity, its impact on one or more major life activities, and to determine reasonable accommodations, your diagnosis and assessment of this student is needed. Documentation must be current (i.e. most recent visit should be within the last 3 months). In some cases, students will be required to provide more frequent updates depending upon the fluid nature of their disability. Please include copies of any relevant adult normed psycho-educational or neuropsychological assessments, including test scores. All information will be kept confidential. In accordance with professional ethics, this form may not be completed by a family member.

Please visit the OSD's website at http://osd.ucsd.edu/students/forms.html#Forms-for-Medical-Professionals and review the documentation guidelines if you need assistance in completing this form thoroughly and completely.

Student Name _____ DOB _____

Name/Title of Certifying Professional (Please print) _____

License # _____ State _____

Address _____

Telephone Number _____ Fax Number _____

Provider Certification:
I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above. In cases where the diagnostic assessment of the student was performed by another clinician, my signature confirms the review of the original assessment and agreement of the diagnosis.

OR

If you feel you **CANNOT** provide documentation for this student, please indicate the reason below:

____ I am not treating this student

____ I have referred to another clinician

____ I would need additional sessions with the student to complete this form

____ Other _____

____ I have not diagnosed this student

____ I have referred for additional evaluation

____ I have insufficient information to describe functional limitations that would impact the student's academic work/major life activities

Signature _____

Date _____

Student Name _____ DOB _____

DSM-5: Please include all relevant diagnostic information including subtypes and/or specifiers for diagnostic domains and subgroups (as indicated in DSM-5) including V/Z codes: psychosocial and environmental stressors.

1. What are the current diagnoses for this student? (Please provide all pertinent DSM-5 codes or diagnoses.)

   Primary: _____

   Secondary: _____

   Psychosocial or Environmental Stressors: _____

   Medical Conditions: _____

2. What is the initial date of the diagnosis(es)? _____
3. Is the student currently under your care for this diagnosis(es)? YES NO
4. When did **you** first see/treat the student for this diagnosis(es)? _____
5. List the dates you saw the student within the last 6 months for this diagnosis(es)? _____

   _____

6. Has this student ever been hospitalized for psychological issues?
   NO YES (dates of hospitalization) _____
7. Has this student ever attempted suicide?
   NO YES (dates) _____
8. Level of Severity without Treatment:

   Mild 1 2 3 4 5 Moderate 6 7 8 9 10 Severe

   Level of Severity with Treatment:

   Mild 1 2 3 4 5 Moderate 6 7 8 9 10 Severe

9. Please indicate which of the following assessments or evaluation procedures were used to arrive at the diagnosis. Include copies of any neuropsychological or psycho-educational testing including test scores.

   [ ] Structured/Unstructured Interviews with the student
   [ ] Interviews with Others
   [ ] Behavioral Observations
   [ ] Developmental History
   [ ] Educational History
   [ ] Medical History
   [ ] Neuropsychological Testing
   Dates: _____
   [ ] Psycho-educational Testing
   Dates: _____
   [ ] Standardized or Non-Standardized Ratings Scales
   [ ] Other (specify) _____

For OSD staff use only:

Student Name _____ DOB _____

10. Activities Assessment: Please check which of the activities are affected because of the diagnosis/ impairment and indicate the level of limitation ***with current treatment protocols***. Please assess all activities. If not applicable, please check the box marked 'No Impact.'
Please indicate whether you have observed this or if it is self-reported.

Activity	No Impact	Mild Impact	Moderate Impact	Severe Impact	Don't Know	**Self-Report**	**Observed by Medical Professional**
Organization							
Concentration							
Memory							
Time Management							
Stress Management							
Sleeping							
Social Interactions							
Attendance							
Managing Distractions							

11. Describe, **in DETAIL,** the student's **current and specific functional limitations related to disability** (i.e., how the student specifically is impacted by disability, how disability impacts the student on a daily basis, what other activities is student unable to do or other areas that are significantly impacted due to disability, etc.). If they have a condition that flares, how often and for what duration do these flares occur?

_____

_____

_____

_____

_____

12. Is the student requesting any Housing accommodations:
Please circle: **YES** **NO**
If YES, please describe **IN DETAIL** how housing accommodations would mitigate the current and specific functional limitations related to the student's disability:

_____

_____

_____

_____

For OSD staff use only:

13. Describe any medications currently being used by the student including type and dosing. How frequently has medication been changed?

    _____

    _____

    _____

14. What are the specific side effects that the student has reported, if any? Explain how the side effects of the medication impact the student's disability.

    _____

    _____

    _____

15. What compensatory strategies are you working with the student on to mitigate the psychological condition? (i.e. coping skills, anxiety-reduction techniques, focusing therapy, time management, etc.)

    _____

    _____

    _____

16. Is the student compliant with his/her treatment plan, medication protocols and/or recommended referrals? YES NO

17. What is the student's prognosis?

    _____

    _____

    _____

18. Please attach any supporting documentation.

For OSD staff use only: