



WESTMONT

DOCUMENTATION OF PSYCHOLOGICAL CONDITION FOR WESTMONT COLLEGE

Students requesting services or accommodations at Westmont College through the Office of Disability Services are to provide current documentation that must be completed by a provider that has provided treatment/evaluation in the past 6 months. Documentation standards to determine legal eligibility may be more stringent than for usual clinical practice.

Eligibility is based upon documented clinical data not simply self- report or evidence of a diagnosis. Office of Disability Services requires more comprehensive documentation in order to determine if the condition rises to the level of disability, and, if so, determine appropriate academic support services.

All information is kept confidential, and cannot be released without written consent from the student. Note that not all conditions listed in the DSM~5 are disabilities, or even impairments for purposes of ADA [*Therefore, a diagnosis does not, in and of itself, meet the definition of a disability necessitating reasonable accommodations under ADA or Section 504 of the Rehabilitation Act of 1973*].

TO BE COMPLETED BY PROVIDER

PLEASE NOTE: All information that you provide will be shared with the student. Thank you for your assistance.

Student Name:
Date:
Student Telephone #:
Email:

I. DSM~5 Diagnosis:

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

Focus of Clinical Treatment	(please provide all pertinent ICD-10-CM diagnoses)
Medical Conditions	

Please indicate the “moderate to severe” symptoms associated with this disorder that currently impact the student:

Overall Level of Severity <i>(check on)</i>	Mild	Moderate	Severe	Partial Remission	Residual State
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II. TREATMENT:

Please provide a brief summary of the diagnostic interview(s). This should include the chief complaint, history of presenting symptoms and past functioning, duration and severity of the disorder, and relevant, developmental, historical and familial data.

Treatment Background:

Number of sessions with student:

Date you first saw the student?

How often do you provide treatment?

When did you last evaluate this student:

Please list other providers the student is in treatment with:

Frequency of treatment with other providers:

Is the student currently a danger to self or others (Explain)?

The student’s condition is: Stable Improving Worsening Cyclically variable

Prognosis: Poor Guarded Fair Good Excellent

Prescribed Medication & Dosages:

Is the student currently being prescribed medications?

Please list medications the student is currently taking:

Is the student compliant with medications?

How long has student been on current medications?

Does the medication mitigate the student’s symptoms? completely partially not mitigated

III. IMPACT ON MAJOR LIFE ACTIVITIES

PLEASE NOTE: We request data based evidence (such as psychoeducational, neuropsychological, and/or norm based behavior assessment. When available, please attach a report that lists all testing results (including standard scores and subtests) and an explanation of how test scores were used to arrive at your conclusion that the components of learning that you checked are substantially affected.

Which, if any, of the other major life activities below, does the impairment(s) affect?

Physical Limitations		Unknown	No Impact	Minimal Impact	Moderate Impact	Severe Impact
	Breathing					
	Caring for self					
	Hearing					
	Learning					
	Performing manual tasks					
	Seeing					
	Speaking					
	Working					
	Walking					
	Other, Please describe:					
Learning Limitations						
Engagement						
	Attending					
	Concentrating					
	Thinking					
	Writing					
	Avoidance please specify behavior: _____					
	Cognitive processing					
	Long term memory					
	Short term memory					
	Effect of anxiety on cognitive functioning					
	Distractibility					
	Reading					

Learning Limitations continued...		Unknown	No Impact	Minimal Impact	Moderate Impact	Severe Impact
	Accessing prior knowledge					
Exploration						
	Decision-making					
	Investigating					
	Organizing					
	Performing					
	Planning					
	Problem solving					
	Time Management					
Explanation						
	Analyzing					
	Reasoning					
	Supporting with evidence					
	Participating in class discussions					
	Giving oral presentations/group projects					
	Reflecting					
Extension						
	Applying understanding to the real world					
	Expanding understanding					
	Processing speed					
Behavioral/Inter-personal Limitation						
	Restricted or labile affect in daily social activity					
	Excessive activity level					
	Impulsivity					
	Fatigue or low energy					
	Frequent emotional outbursts					
	Irritability/agitation					

Behavioral/Inter-personal Limitation continued...		Unknown	No Impact	Minimal Impact	Moderate Impact	Severe Impact
	Restlessness					
	Interpersonal fears or suspiciousness					
	Preoccupation with self					
	Rambling, pressured speech					
	Changes in appetite					
	Avoidance of social interactions					
	Attending class					
	Changes in sleeping (please specify: _____)					
	Initiating work					
	Suicidal ideation _active _passive					
	Motivation					
	Difficulty initiating interpersonal conduct					
	Other, please specify:					
Perceptual Limitations						
	Visual hallucinations					
	Auditory hallucinations					
	Other, please specify:					
Medication Side Effects						
	Drowsiness					
	Blurred Vision					
	Restlessness					
	Fatigue					
	Confusion					
	Thirst					

Medication Side Effects continues		Unknown	No Impact	Minimal Impact	Moderate Impact	Severe Impact
	Memory Loss					
	Anxiety					
	Other, please specify					

IV ASSESSING FUNCTIONAL LIMITATIONS

What methods were used to determine the impact on major life activities?

Structured or Unstructured interviews with the student.
Please explain:

Interviews with other persons.
Please explain:

Behavioral Observations.
Please explain:

Developmental History.
Please explain:

Educational History.
Please explain:

Medical History.
Please explain:

Neuro-psychological testing. Attach results. Dates of testing:

Psycho-Educational Testing. Attach Results. Dates of Testing:

Standardized or non-standardized rating scales. Please explain.

Other (Please Specify):

Recommendations for possible accommodations

Diagnosing Professional Signature _____

Please Print name _____

License/Certification number: _____

Address: _____

Telephone: _____

Fax: _____

Date form completed _____

Please send your report to ODS at (805) 565-7244 Confidential FAX, or mail to: Westmont College
Office of Disability Services 955 La Paz Rd. Santa Barbara, California, 93108.
Please call (805) 565-6135, or (805) 565-6186 if you have questions or concerns.