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:<br>Date:<br>Student Telephone #:<br>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 *(check on)* | Mild | Moderate | Severe | Partial Remission | Residual State |
|---|---|---|---|---|---|
| | | | | | |

**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____________________________________________________

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Please send your report to ODS at ods@westmont.edu, or (805) 565-7244 for 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.