

## DOCUMENTATION OF PSYCHOLOGICAL CONDITION FOR UC SANTA BARBARA

Students requesting services or accommodations at UCSB through the Disabled Students Program are required 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. DSP 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.

The student will be completing the WHODAS 2.0 (World Health Organization Disability Assessment Schedule 2.0, 36 item version, self-administered through UCSB DSP)

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

### TO BE COMPLETED BY PROVIDER

Student Name: Date: Student Telephone #: Full 7 digit Perm#: Email:
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#### 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 DSM 5 codes or diagnoses)
Medical Conditions	

Overall Level of Severity <i>(check one)</i>	Mild	Moderate	Severe	Partial Remission	Residual State
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Please indicate the “moderate to severe” symptoms associated with this disorder that currently impact the student:

## 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 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)?

Has the student ever been hospitalized for psychiatric reasons? Please Explain.

The student's condition is:  stable  improving  worsening  cyclically variable

Prognosis?  Poor  Guarded  Fair  Good  Excellent

### **Prescribed Medications & 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 the student been on current medication?

Does 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 behavioral assessments. 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?

		unknown	No Impact	Minimal Impact	Moderate Impact	Severe Impact
<b>Physical Limitations</b>						
	Breathing					
	Caring for self					
	Hearing					
	<b>Learning</b>					
	Performing manual tasks					
	Seeing					
	Speaking					
	Working					
	Walking					
	Other, please describe:					
<b>Learning Limitations</b>						
<b>Engagement</b>						
	Attending					
	Concentrating					
	Thinking					
	Writing					
	Avoidance (please specify behavior: _____)					
	Cognitive processing					
	Long term memory					
	Short term memory					
	Effect of anxiety on cognitive functioning					
	Distractibility					
	Difficulty in adapting to new learning situations					
	Reading					
	Accessing prior knowledge					

		unknown	No Impact	Minimal Impact	Moderate Impact	Severe Impact
<b>Learning Limitations Continued</b>						
<b>Exploration</b>						
	Answering					
	Decision-making					
	Investigating					
	Organizing					
	Performing					
	Planning					
	Problem solving					
	Time management					
<b>Explanation</b>						
	Analyzing					
	Reasoning					
	Supporting with evidence					
	Participating in class discussions					
	Giving oral presentations/group projects					
	Reflecting					
<b>Extension</b>						
	Applying understanding to the real world					
	Expanding understanding					
<b>Evaluation</b>						
	Demonstrating knowledge on instructor generated scoring tools					
	Processing speed					
<b>Behavioral/Interpersonal Limitations</b>						
	Restricted or labile affect in daily social activity					
	Excessive activity level					
	Impulsivity					
	Fatigue or low energy					

		unknown	No Impact	Minimal Impact	Moderate Impact	Severe Impact
<b>Behavioral/Interpersonal Limitations Continued</b>						
	Frequent emotional outbursts					
	Irritability/agitation					
	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:					
<b>Perceptual Limitations</b>	Visual hallucinations					
	Auditory hallucinations					
	Other, please specify:					
<b>Medication Side Effects</b>	Drowsiness					
	Blurred Vision					
	Restlessness					
	Fatigue					
	Confusion					
	Thirst					
	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):

Diagnosing Professional Signature \_\_\_\_\_

Please Print Name \_\_\_\_\_

License/Certification number: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

Date form completed \_\_\_\_\_

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Please send your report to DSP at (805) 893-7127 FAX, or mail it to: University of California, Disabled Students Program, Santa Barbara, CA 93106-3070. Please call (805) 893-2668, if you have any questions or concerns.