RARITAN VALLEY COMMUNITY COLLEGE

Center for Accessibility & Inclusive Education
P.O. Box 3300 * Somerville, NJ 08876
Phone: (908) 526-1200 ext. 8534 Fax (908) 526-3494
caie@raritanval.edu

Psychological Disability Documentation Form

Please complete this form with as much detail as possible, as a partially completed form or limited responses may hinder the eligibility process. It is most important that you **thoroughly** explain any psychological symptoms and indicate their impact on functioning. If you wish to provide additional information, please attach it to this form.

Thank you for your assistance.

To be completed by the treating, licensed healthcare professional only

Student's name: _____

Today's date: _____

Date of diagnosis: _____

Date student was last seen: _____

DSM Diagnoses

Axis/Category I: _____

Axis/Category II: _____

Axis/Category III: _____

Axis IV (if needed): _____

Axis V (if needed) (GAF Score): Present time: _____ Over last year: _____

In addition to DSM criteria, how did you arrive at your diagnosis? Please check all items that apply below:

- ☐ Structured or unstructured interviews with patient.
- ☐ Interviews with other persons: _____
- ☐ Behavioral observations
- ☐ Developmental History
- ☐ Educational History
- ☐ Medical History
- ☐ Neuropsychological testing. Dates/Instruments: _____
- ☐ Psycho-educational testing: Dates/lnstruments: _____
- ☐ Standardized rating scales: _____
- ☐ Other: _____

What is the severity of the condition? ☐ Mild ☐ Moderate ☐ Severe

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What is the expected duration? ☐ Chronic (more than a year) ☐ Episodic ☐ Short-term (six months - one year)

Please explain severity and duration: _____

Provide information regarding the impact, if any, of the condition on a specific major life activity (e.g., learning, eating, walking, interacting with others, etc.):

_____

_____

_____

State the student's functional limitations from the disorder specifically in a classroom or educational setting:

_____

_____

_____

List the student's current medication(s), including dosage, frequency, and adverse side effects (if applicable):

_____

_____

Are there significant limitations to the student's functioning directly related to the prescribed medications?

___ Yes ____ No If yes, explain: _____

Please provide your specific recommendations (based upon your assessment, the student's clinical and academic history, and diagnosis) for reasonable accommodations that you believe will help equalize the student's ability to access the RVCC's educational program along with rationale for each):

_____

_____

_____

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Additional information you believe would be helpful in determining the nature and severity of this student's disability, and any additional recommendations that may assist the CAIE in determining appropriate accommodations:

_____

_____

_____

Certifying Professional

_____ _____
Name and Title Area of Specialty

_____ _____
License Number State of Licensure

_____ _____
Address Phone Number

_____ _____
City, State, Zip Fax Number

_____ _____
Signature of Certifying Professional Date

Please return to:

Center for Accessibility and Inclusive Education
Raritan Valley Community College
118 Lamington Road
College Center, C-124
Branchburg, NJ 08876
Fax: (908) 526-3494
Email: caie@raritanval.edu