RARITAN VALLEY COMMUNITY COLLEGE

Disability Services
P.O. Box 3300 * Somerville, NJ 08876
Phone: (908) 526-1200 ext. 8534
Fax (908) 526-3494
disabilityservices2@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/Instruments: ______________________________
- ☐ 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 DS 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:

Office of Disability Services
Raritan Valley Community College
118 Lamington Road
College Center, C-124
Branchburg, NJ 08876
Fax: (908) 526-3494
Email: disabilityservices2@raritanval.edu