UC RIVERSIDE | UNIVERSITY OF CALIFORNIA | Student Disability Resource Center

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sdrc.ucr.edu

CERTIFICATION OF PSYCHOLOGICAL DISABILITY

The student named below has applied for services from the Student Disability Resource Center at UC Riverside. In order to determine eligibility and to provide services, we require documentation of the student's psychological disability. Under the Americans with Disabilities Act as Amended (ADAAA) of 2008 and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. To establish that an individual is covered under the law, documentation must indicate that a specific disability exists and that the identified disability substantially limits one or more major life activities. A diagnosis of a disorder in and of itself does not automatically qualify an individual for accommodations. The documentation must support the requested accommodation(s).

Please return completed form to SDRC. The information you provide will *not* become part of the student's academic records, but will be kept in the student's file at SDRC, where it will be held in accordance with federal laws regarding privacy of student records. This form may be released to the student at their request. In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment. Please contact us if you have questions or concerns. Thank you for your assistance.

Student's Name: _____ Student's UCR Email_____

Today's Date: _____ Initial Date of Diagnosis (below):_____
Date Student was Last Seen: _____ Number of sessions for this diagnosis: _____

What is the nature of the student's mental health impairment?
DSM-V DIAGNOSIS (include DSM V or ICD 10 Codes, include subtypes and specifies)

Principle Diagnosis: _____

Other Diagnosis: _____

Other Diagnosis: _____

Other Diagnosis: _____

Other Diagnosis: _____

1. In addition to DSM-V criteria, how did you arrive at your diagnosis? Please check all relevant items below, ***adding brief notes that you think might be helpful to us as we determine which accommodations and services are appropriate for the student.***

Check Assessment or Evaluation Procedure use to Make Diagnosis	
☐ Structured or unstructured interviews with the student	☐ Interviews with other persons
☐ Developmental history	☐ Behavioral observations
☐ Neuropsychological testing Date(s) of testing- Attach Report	☐ Medical history
☐ Psychoeducational testing Date(s) of testing- Attach Report	☐ Educational history
☐ Standardized or non-standardized Rating scales –Attach Report	☐ Other (please specify):
Notes (to assist in determining accommodations):	

2. What medications have you prescribed the student? ☐ N/A, I do not prescribe medication.

List Side effects: ☐ No Known Side Effects; or ☐ _____
Effectiveness of Medication(s): ☐ Very Effective ☐ Moderately Effective ☐ Somewhat Effective ☐ Unknown

3. Please check which of the major life activities below are affected because of the psychological diagnosis. Please indicate the level of limitation.

Life Activity	**No Impact**	**Mild Impact**	**Moderate Impact**	**Severe Impact**	**Don't Know**
Concentration/Focus					
Managing internal stimuli					
Managing external stimuli					
Information Processing					
Organization / planning					
Initiation					
Recall/Memory					
Motivation					
Difficult Making Decisions					
Subject to flare up / episodes					
Stamina					
Stress management					
Emotional regulation					
Social interactions					
Distress Tolerance					
Eating					
☐ Insomnia / ☐ Hypersomnia					
Other (please explain):					

4. What other specific symptoms are manifesting themselves at this time that might affect the student's academic performance?

5. Prognosis: What is the anticipated length of impact to the student's functional limitations?
Check One: ☐3 months or less ☐ ≈ 6 months ☐ ≈ 1 year ☐Permanent/Chronic ☐Unknown

6. Treatment Plan: How often will you be seeing the student for treatment of this diagnosis?
☐ No f/u appointments scheduled ☐ Specify frequency:_____

7. Is there anything else you think we should know about the student's disability?

CERTIFYING LICENSED PROFESSIONAL*

Printed Name: _____ Signature: _____

License Number: _____

☐Psychologist ☐Psychiatrist ☐Neurologist ☐Primary Care Physician ☐LCSW/LMFT

Address: _____City_____State_____Zip_____

Telephone: _____Fax: _____

* The diagnosing professional must be licensed to work independently and have expertise in the differential diagnosis of the documented mental disorder and follow established practices in the field. Practitioners who function under physician oversight (e.g., PA, NP…), or licensed mental health care professionals (e.g. Psych intern, MFTI,…), must have this form signed by the supervising license. In accordance with professional ethics, this form may not be completed by a family member.