



# FERRIS STATE UNIVERSITY

## Educational and Career Counseling Center and Disabilities Services

### Psychiatric/Psychological Disability Professional Documentation/Verification Form

This form is for Psychiatric/Psychological Disabilities only. Autism Spectrum/Pervasive Developmental Disorders require completion of the *Autism Spectrum/Pervasive Developmental Disorder Documentation/Verification Form*; Medical, Physical and Sensory conditions require the completion of the *Physician's Statement of Long Term Medical, Physical and/or Sensory Disability Documentation/Verification Form*; ADD/ADHD conditions require the completion of the *ADD/ADHD Verification Form* and the *Physicians Statement of Long Term Medical, Physical and/or Sensory*

#### **Please Review Carefully**

The student named below has applied for accommodations from Ferris State University due to the impact of a Psychiatric/Psychological Disorder. Students seeking accommodations must provide appropriate medical documentation of their condition so that the University can: a) determine eligibility for accommodations, and b) if eligible, determine appropriate accommodations.

**Documentation required to verify the student's condition and its severity, includes completion of this form or provision of equivalent information to Disabilities Services by a professional with the appropriate training and credentials.** Depending on the condition, the appropriate professional should be a licensed psychiatrist, psychologist, neurophysiologist, or other qualified and licensed clinical mental health professional (LMSW, LPC). Any professional completing this form must have first-hand knowledge of the condition, experience in working with students with psychiatric/ psychological conditions and a familiarity with the physical, emotional and cognitive demands experienced by students in an academic setting. Diagnoses of psychiatric/psychological disabilities documented by family members are unacceptable.

Disabilities Services at Ferris State University provides services and accommodations to persons with disabilities to ensure equal access to educational programs and activities. A disability must substantially limit one or more major life activity, such as walking, seeing, hearing, speaking, breathing, learning, caring for one's self, performing manual tasks and working.

Current and comprehensive disability documentation is required to assist with the provision of appropriate and reasonable accommodations and/or auxiliary aids. Additional documentation may be required.

**Ferris State University / University College / Department Head  
Educational and Career Counseling Center & Disabilities Services  
901 S State Street, Starr 313  
Big Rapids, Michigan 49307  
Phone & TDD (231) 591-3057 Fax (231) 591-3939  
E-mail: [disabilities@ferris.edu](mailto:disabilities@ferris.edu)**



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## Educational and Career Counseling Center and Disabilities Services

### *Verification Form for Psychiatric/Psychological Disorders*

**Student: Complete this section.**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Campus Wide I.D. (CWID): \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I, \_\_\_\_\_, authorize the identified health care provider to release to Disabilities Services the medical information requested on this form for the purpose of determining appropriate accommodation for my psychiatric/psychological disability while a student at Ferris State University. I also authorize my provider to discuss my disability with Disabilities Services Counseling staff for clarification and continuity of care.

Signature of patient: \_\_\_\_\_ Date: \_\_\_\_\_

If under 18 and/or signed by person other than patient, state relationship and authority to do so.

Relationship: \_\_\_\_\_ Legal Authority: \_\_\_\_\_

**Certifying Professional: Complete this section including the rest of this form.**

Today's Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

**Signature denotes: content accuracy, adherence to professional standards and guidelines as stated above.**

License Type: \_\_\_\_\_

License Number: \_\_\_\_\_ State \_\_\_\_\_ Exp Date \_\_\_\_\_

Area of Specialization: \_\_\_\_\_ Title: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_



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## Educational and Career Counseling Center and Disabilities Services

### Diagnostic and Statistical Manual Diagnosis (DSM)

Axis I: \_\_\_\_\_ Code \_\_\_\_\_  
 Axis II: \_\_\_\_\_ Code \_\_\_\_\_  
 Axis III: \_\_\_\_\_ Code \_\_\_\_\_  
 Axis IV: \_\_\_\_\_ Code \_\_\_\_\_  
 Axis V: \_\_\_\_\_ GAF Score \_\_\_\_\_  
 Primary diagnosis/diagnoses and date of onset: \_\_\_\_\_

Date of onset/DX: \_\_\_\_\_ Severity of Condition: Mild Moderate Severe In Remission

Procedures/assessments used to diagnose this student's condition: \_\_\_\_\_

### Diagnostic Tools

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

- Interviews with the client
- Interviews with other persons
- Behavioral observations
- Developmental history
- Medical history
- Neuro-psychological testing
- Psycho-educational testing
- Self rated or interviewer rated scales
- Other

Is there a periodic evaluation of the individual's condition? \_\_\_\_\_ If so, how often? \_\_\_\_\_

The psychiatric or psychological disability is: Permanent/chronic  
 Long-term 6-12 months  
 Short-term/temporary: 6 months or less  
 Expected Duration \_\_\_\_\_



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Describe the student's present symptoms that meet the criteria for diagnosis: \_\_\_\_\_

\_\_\_\_\_

What are the current functional limitations of this individual? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Client's last appointment: (check one)

< month

<1 yr

>1 yr

Appointment frequency: (check one)

weekly  monthly  annually  as needed

How long do you anticipate that the client's academic achievement will be impacted by the primary condition?

Permanent/chronic

Long-term 6-12 months

Short-term/temporary: 6 months or less

Expected Duration \_\_\_\_\_

Relevant Psychiatric History: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of Last Psychiatric Hospitalization: \_\_\_\_\_

Evidence of Suicidal Ideation \_\_\_\_\_

Evidence of Homicidal Ideation \_\_\_\_\_



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Treatment \_\_\_\_\_

Evidence of Hallucinations \_\_\_\_\_

Type \_\_\_\_\_

Treatment \_\_\_\_\_

Prognosis: \_\_\_\_\_

\_\_\_\_\_

### Medication and Prescribed Aids

What medication and prescribed aids are currently being used in the treatment of the diagnosis/diagnoses above? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is the client compliant with medication and prescribed aids as part of the treatment plan? If no, please explain. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe any medication side-effects that may adversely affect the client's academic performance.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do limitations/symptoms persist even with medications and /or prescribed aids? If so what specific limitations/symptoms exist? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Impact of Diagnosis

Describe the level of severity with which the disability and any related treatment, as well as any other relevant aspects of this condition that may impact overall current general functioning.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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Describe the manner and level of severity with which the disability has a current and substantial impact on social and interpersonal functioning.

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Describe the manner and level of severity of the student's functional limitations with which the disability has a current and substantial impact on academic functioning (e.g. reading, memorizing, writing, note-taking, test-taking, etc.) on learning and the degree to which it impacts the individual in the academic setting for which accommodations are being requested.

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Describe the presence of compensatory strategies employed by the student in any of the DSM-IV diagnostic criteria: \_\_\_\_\_

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Document all prior accommodations and treatments: \_\_\_\_\_

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Describe any referrals and/or suggestions with accompanying rationale for each, made for further testing, evaluation, treatment or therapy.

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**Optional comments:** Please use the space below (and additional sheets as needed) to provide any information that will be helpful to the Disabilities Services Staff in considering the accommodations you are recommending. \_\_\_\_\_

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## Educational and Career Counseling Center and Disabilities Services

### Major Life Activity

For each major life activity listed, denote the level of impact for **both without and with** medication and prescribed aids.

Life Activity		No Impact	Moderate Impact	Substantial Impact	Don't Know
<b>A. Concentration</b>	Without	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	With	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>B. Long Term Memory</b>	Without	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	With	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>C. Short Term Memory</b>	Without	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	With	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>D. Sleeping</b>	Without	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	With	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>E. Eating</b>	Without	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	With	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>F. Social Interactions</b>	Without	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	With	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>G. Self-Care</b>	Without	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	With	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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## Educational and Career Counseling Center and Disabilities Services

### Major Life Activity Continued

For each major life activity listed, denote the level of impact for **both without and with** medication and prescribed aids.

Life Activity		No Impact	Moderate Impact	Substantial Impact	Don't Know
<b>H. Managing Internal Distractions</b>	Without	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	With	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>I. Managing External Distractions</b>	Without	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	With	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>J. Timely Submissions of Assignments</b>	Without	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	With	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>K. Attending Class Regularly and on Time</b>	Without	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	With	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>L. Making and Keeping Appointments</b>	Without	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	With	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>M. Stress Management</b>	Without	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	With	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>N. Organization</b>	Without	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	With	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>