UC RIVERSIDE | Student Disability Resource Center

900 University Ave., 1228 Student Services Build.,
Riverside, CA 92521
P (951) 827-3861
https://sdrc.ucr.edu
Submit completed form to 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@ucr.edu. 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 (please sign this form before providing it to your mental health care provider to complete):**
By signing below, I consent to allowing my health care provider to share any information relevant to my need for disability related accommodations, as shown on this form, with (personnel from the SDRC office) for the next 60 days.

Student Name (Print) _____(signature)_____Date_____
Student UCR email:_____

**TO BE COMPLETED BY THE LICENSED PROVIDER (incomplete information may nullify this request):**
Patient Name: _____ Today's Date: _____
Initial Date of Diagnosis (below):_____ Date of most recent appt: _____
Number of sessions for this diagnosis: _____

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

Principle 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 | |
| **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** | **Rate the Impact** | | | | | **Notes** |
|---|---|---|---|---|---|---|
| | **N/A** | **Mild** | **Moderate** | **Severe** | **Don't Know** | |
| Concentration/Focus | | | | | | |
| Managing internal stimuli (thoughts) | | | | | | |
| Managing external stimuli | | | | | | |
| Information Processing | | | | | | |
| Organization / planning | | | | | | |
| Initiation- difficulty getting started | | | | | | |
| Recall/Memory | | | | | | |
| Motivation (identifying reasons to act) | | | | | | |
| Difficult Making Decisions | | | | | | |
| Issues with energy | | | | | | |
| Stress management | | | | | | |
| Emotional regulation | | | | | | |
| Social interactions | | | | | | |
| Distress Tolerance | | | | | | |
| Eating | | | | | | |
| ☐ Insomnia / ☐ Hypersomnia | | | | | | |

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

5. If there are flare up, please provide frequency, intensity, and duration (i.e., hospitalizations). Also, what other symptoms, if any are present during a flare up?

6. 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* must be eligible to practice without supervision.

Printed Name: _____ Signature: _____

License Number: _____ Date:_____

☐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.**