COLUMBIA HEALTH
Disability Services

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VERIFICATION OF DISABILITY FOR MENTAL HEALTH TREATMENT PROVIDERS

Purpose: The student named below has indicated that s/he has a disability and will require reasonable accommodations to participate in a program or activity at Columbia University. The information you provide will be one of the criteria used to evaluate the student's eligibility for the requested accommodations or services. **Please take the time to complete this form in its entirety.** All information provided will be kept confidential in accordance with the Family Educational Rights and Privacy Act (FERPA).

Student Name: ______________________________ UNI:____________

Current DSM-IV-TR Diagnosis (es):

Axis I: ______________________ Date of Diagnosis: ______________________

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Axis II: ______________________ Date of Diagnosis: ______________________

Axis III: ______________________ Date of Diagnosis: ______________________

Axis IV: ______________________ Date of Diagnosis: ______________________

Axis V (Current GAF Score):______________________

Dates of treatment with current provider/facility:

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Date student was last seen: ________________________________

Please provide details regarding student's treatment history, current plan and expected duration (counseling, medication, etc that is relevant to current status / request for accommodations:

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Current Status of Condition(s) (e.g. Active, Progressing, Controlled, In Remission), provide details:

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In addition to DSM-IV-TR criteria, how did you arrive at your diagnosis?

- ◻ Clinical interviews with student
- ◻ Interview with other persons
- ◻ Behavioral observations
- ◻ Review of medical records
- ◻ Review of educational records
- ◻ Standardized rating scale
- ◻ Neuro/psychological testing; Dates: ____
- ◻ Other- please specify: ____

Please describe the student's symptoms relating to the diagnosis(es): ___________________________

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How long is this condition(s) likely to persist (*be as specific as possible: e.g. lifetime, one academic year, one semester, one month*):

____

What are the student's current functional limitations (*again, be as specific and detailed as possible and provide information for all disability areas*): 1) time management and organization; 2) self care or social interactions; 3) sleeping; 4) cognitive processes—concentration, memory, rapidity of information processing, fatigability, 5) Ability to attend or participate in class:

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In comparison to the average person in the general population, please rate the severity of the student's functional limitations noted above, both with and without the use of mitigating measures (interventions), such as medication and treatment:

Without Mitigation (Intervention):	**With Mitigation (Intervention):**
Mild ◻	Mild ◻
Moderate ◻	Moderate ◻
Substantial ◻	Substantial ◻
Severe ◻	Severe ◻

What exacerbates the specific disability(ies) this student has? (Be as specific and detailed as possible)

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Please provide the following information regarding any medications related to the condition(s) that the student is currently prescribed:

Medication	Dosage	Frequency	Positive Effects	Adverse effects

Please describe the impact this condition has on the student's overall ability to learn:

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____

Recommendations for accommodations:

____

____

____

Anticipated duration of need for accommodation: ____________________________________

____

Name & Credentials of Treatment Provider: ____________________________________

License #: ________________________________ **State:**____________________

Address: ____

Telephone: ____

Signature: ____________________________ **Date:** __________________________

□ **I herby certify that the above information is true and correct and that the information provided is objective medical/ psychological information relative to this student's application for disability accommodations.**

□ **I am not related to the student by blood or marriage**.