COLUMBIA HEALTH
Disability Services

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Verification of Disability Form 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: ____________________

Date student was last seen: ____

Dates of treatment with current provider/facility: ____

Current Principal DSM-V Diagnosis with numerical code including specifier and subtype, if applicable:

____ Date of Diagnosis: ______________

Additional Diagnosis(es) in the order of focus of attention and treatment :

____ Date of Diagnosis: ______________

____ Date of Diagnosis: ______________

Associated Medical Condition(s), if applicable:

____ Date of Diagnosis: ______________

____ Date of Diagnosis: ______________

Current Status of each of the above condition(s) (e.g. Active, Progressing, Controlled, In Remission):

____

____

In addition to DSM-V criteria, how did you arrive at your diagnosis? Please check all that apply.

☐ Clinical interviews with student
☐ Review of medical records
☐ Interviews with other persons
☐ Review of educational records
☐ Behavioral observations
☐ Neuropsychological testing (include dates): __________
☐ Standardized rating scale/assessment (please specify): ______________________________________
☐ Other (please specify): ____

In your current clinical assessment, please indicate the degree of the student's functional limitations on most days, keeping in mind the positive and negative effects of any treatment modalities and/or their personal circumstances:

☐ **Mild** ☐ **Moderate** ☐ **Substantial** ☐ **Severe**

Be as specific and detailed as possible to what exacerbates the student's condition(s) and any relevant psychosocial and contextual factors:

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Please provide details regarding the following:

1. **Student's treatment history:** ____

____

____

2. **Current treatment plan and expected duration of treatment (psychotherapy, medication, etc.):**

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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 way(s) that the student's condition presents for the student and/or how the student is individually impacted:

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What are the student's current functional limitations with respect to the following areas? Please list below:

1) Time management and organization: ____

____

____

2) Executive Functioning/ planning:____

____

____

3) Self-care or social interactions: ____

____

____

4) Sleeping: ____

____

____

5) Cognitive processes such as concentration, memory, rapidity of information processing, fatigability: ________

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____

6) Ability to attend or participate in class: ____

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____

7) Learning: ____

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____

8) Other: ____ -

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Please provide specific recommendations regarding academic accommodations for this student, and a rationale as to why these accommodations/services are warranted, based upon the student's functional limitations (e.g. if a note taker is suggested, state the reasons for this request related to the student's symptoms).

Recommended accommodation: ____

Rationale: ____

____

Recommended accommodation: ____

Rationale: ____

____

Recommended accommodation: ____

Rationale: ____

____

Anticipated duration of need for accommodation: ____

Other pertinent information that would be helpful when determining accommodations for student:

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Please check the following that apply:

- ☐ **I am the primary person involved in the student's treatment**
- ☐ **I am a part of the student's treatment team**
- ☐ **The student is my former patient, who is currently under the care of another provider**
- ☐ **I was the original person who diagnosed this student as having a disability**

Name & Credentials of Treatment Provider: ____

License #: ____ **State:**____________________________________

Address: ____

Telephone: ____

Signature: ____ **Date:** ______________________________________

☐ **I hereby 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**