

**Lebanon Valley College**  
**DOCUMENTATION OF PSYCHOLOGICAL DISORDER**

I am referring \_\_\_\_\_ to the Office of Disability Services. By our current definition, a **psychological** disability is coded on *DSM IV-TR* Axis I or II as moderate to severe, has a Global Assessment of Functioning (GAF) score of 60 or below, and interferes with major life functions.

I, \_\_\_\_\_, hereby authorize the exchange and release of the following confidential information, to the Office of Disability Services at Lebanon Valley College, for the purpose of determining my eligibility for educational accommodation. To qualify for services, the Office of Disability Services will need verification now and every 12 months for which services are requested.

Please forward the completed **form** to Dr. Yvonne Foster, Director of Disability Services at 101 North College Avenue, Annville, PA 17003 in Humanities 206 (717-867-6071) or fax to (717-867-6091).

1. *DSM IV-TR*

AXIS I:

AXIS II:

AXIS III:

AXIS IV:

AXIS V:

Date of Diagnosis:

Date of Last Visit:

How often do you regularly meet with this student?

2. Does this condition interfere with one of the following major life activities?

- |                                    |                                                  |
|------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> breathing | <input type="checkbox"/> working                 |
| <input type="checkbox"/> walking   | <input type="checkbox"/> performing manual tasks |
| <input type="checkbox"/> hearing   | <input type="checkbox"/> learning                |
| <input type="checkbox"/> seeing    | <input type="checkbox"/> seeing                  |

3. Does the student have a mental condition that is due to a medical condition? (e.g. Mood Disorder due to a Medical Condition or Anxiety Disorder Due to Medical Condition) Please specify the medical condition, treatment and what accommodations the student may require.

4. Describe the functional **limitations** and/or behavioral manifestations: (e.g., easily distracted, poor concentration, difficulty focusing for extended period of time, difficulty formulating and executing plan of action, difficulty overcoming unexpected obstacles, panic in unfamiliar surroundings and situations, etc.) and recommendations you have prescribed:

5. List any medication(s) prescribed and side effects being experienced:

6. Describe information you have concerning this student's intellectual strengths and weaknesses:

7. The following academic accommodations may or may not be appropriate. Which would you recommend?

- Extended time on tests
- Priority seating
- Audio-taped class lectures
- Limited class load
- Peer note takers or notes provided by instructor
- Separate test administration (distraction free environment)
- Copies of overheads and PowerPoint presentations
- Flexible deadlines on assignments, negotiated on a case-by-case basis
- Flexibility in class attendance on a case-by-case basis (with limitations)
- Access to elevators
- Other (please specify)

Physician's Name Typed or Printed:

Physician's Signature:

Date:

Psychologist Name Typed or Printed:

Date:

Psychologist Signature:

E-mail:

Phone: