Guidelines for Documentation of Psychological Disorders

Lenoir Community College provides academic adjustments, auxiliary aids and/or services to students with disabilities. In order for a student to be eligible for academic adjustments, auxiliary aids, and/or services, the student's documentation regarding the disorder must demonstrate a disability covered under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990. These laws **define a disability as a physical or mental impairment that substantially limits one or more major life activities.** To determine eligibility for academic adjustments, auxiliary aids, and/or services, LCC requires current and comprehensive documentation of the student's disorder. It is the responsibility of the student to obtain documentation and present a copy to the ADA Counselor. The documentation will be reviewed to determine eligibility for academic adjustments, auxiliary aids, and/or services.

Documentation of a psychological disorder must include the completion of the Documentation Form for Psychological Disorders by a licensed psychologist or psychiatrist (documentation for psychological disorders may require periodic updates, especially if changes occur in the student's functioning or requests for academic adjustments, auxiliary aids, and/or services change). In addition to the Documentation Form for Psychological Disorders, a summary report of the student's disorder may be submitted.

A summary of the guideline categories for documenting a psychological disorder is as follows:

1. Presenting concerns at the time of evaluation;
2. Pertinent history (developmental, family, medical, psychosocial, psychological, pharmacological, educational, and employment);
3. Current symptoms
4. A DSM-IV–diagnosis with corresponding DSM-IV code;
5. Functional limitations
6. Summary and recommendations.

Please remember to sign and date the form once it is printed out.

Send the completed report to:

Disability Services Counselor
Lenoir Community College
PO Box 188
Kinston NC 28502
Fax: 252-233-6879 Phone: 252-527-6223 x 331

STUDENT'S NAME:

LCC ID #: If LCC ID is not known, fill in **Social Security#:**

1. What is the student's diagnosis as expressed in DSM-IV codes?

   a. How long has the student had this disorder?

   b. What is the severity of the disorder? Mild Moderate Severe

   Explain the severity checked above:

   c. What is the expected duration? Chronic Episodic Short-term

   Explain the duration checked above:

2. State the following:

   a. Date of first contact with student:

   b. Date of last contact with student:

   c. Date(s) current psychological assessment completed:

   d. Frequency of appointments with student (e.g., once a week, twice a month):

e. What is the student's GAF rating?

3. Student's Current Symptoms and Concerns:

a. Presenting Concerns. Provide information regarding the student's current presenting concerns:

b. Specific Symptoms. Provide information regarding the student's current symptoms:

4. Explain how the symptoms related to the student's disorder cause **significant impairment** in a **major life activity** (e.g., learning, eating, walking, interacting with others, etc.) in a classroom setting, if applicable.

5. List the student's current medication(s), dosage, frequency, and adverse side effects.

   a. Are there significant limitations to the student's functioning directly related to the prescribed medications?

      Yes ☐ No ☐

   b. If yes, explain:

   c. Provide an explanation of the extent to which the medication currently mitigates the symptoms of the disorder.

6. Provide information regarding the **impact**, if any, of the disorder on a **specific major life activity** (e.g., learning, eating, walking, interacting with others, etc.).

7. State the student's **functional limitations** from the disorder specifically in a classroom or educational setting:

8. State specific recommendations regarding academic adjustments, auxiliary aids, and/or services for this student, and a **rationale** as to the reason these academic adjustments, auxiliary aids, and/or 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 condition).

9. If current treatments (e.g., medications) are successful, state the reasons the above academic adjustments, auxiliary aids, and/or services are necessary?

The provider should also send any reports that provide additional related information. The provider completing this form cannot be a relative of the student. The provider signing this form must be the same person answering the questions on the form above.

Signature of Provider: _____ Date: _____

License #: _____ State: _____

(Please Print or Type)

Name/Title:

Address:

Phone:

Revised September 10, 2009