Mental Health Disability Documentation Packet

The Department of Disability Services is responsible for providing students with disabilities equal access to their education. To receive academic adjustments under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA), students at Texas A&M University must provide documentation from an appropriately trained evaluator demonstrating a disability as defined by federal legislation.

Federal law requires that students' requests for academic adjustments, auxiliary aids, and other accommodations be determined on a case-by-case basis. This form was created to facilitate the individualized review of each student request so that Disability Services may determine what, if any, academic adjustments, auxiliary aids, and/or accommodations a student with a Mental Health Disability may be eligible to receive.

This information submitted to Disability Services should reflect the most currently available information. **This Mental Health Disabilities Documentation Packet should:**

a) ***Be completed by a qualified professional.***
b) ***Be completed as clearly and thoroughly as possible.*** Incomplete responses and illegible handwriting will require additional follow up that will delay the review process.
c) ***Be supplemented with any evaluative reports that may provide a more complete understanding of the student.*** Evaluative reports may include comprehensive diagnostic reports such as psycho-educational or neuropsychological reports. Please do not provide case notes or rating scales without a narrative that explains the results.
d) ***Be submitted to the Department of Disability Services.*** All documentation will be held strictly confidential as a student record. This form may be released at the student's request.

Submit Information to:
Disability Services, Texas A&M University
701 West Campus Boulevard; 1224 TAMU
College Station, TX 77843-1224
PHONE: (979) 845-1637
FAX: (979) 458-1214

Date: ___________________

Student Name: ____ Birthdate: __________
Last First M.I.

1. Date of first contact with this individual:________________________________

Date of last contact with this individual: ________________________________

2. DSM-V Diagnosis:

Primary Diagnosis: ____

Severity: _____ Mild _____ Moderate _____ Severe

Secondary Diagnosis: ____

Severity: _____ Mild _____ Moderate _____ Severe

Tertiary Diagnosis: ____

Severity: _____ Mild _____ Moderate _____ Severe

3. How did you arrive at your diagnosis? Please check all that apply.
____ Behavioral Observations
____ Developmental History
____ Educational History
____ Medical History
____ Clinical Interview (Structured or Unstructured)
____ Interviews with Others
____ Rating Scales
____ Neuropsychological Testing (Dates of testing: ______________________________)
____ Other – Please specify: ____

4. Discuss any ***currently prescribed medication or treatment plans***, including dosages and effectiveness.

5. **Please check all applicable functional limitations presented as a result of this student's disability:**

Attendance (If any are checked, see question 6):

_____ is sometimes unable to attend class or other activities due to her/his disability

_____ needs to sometimes leave class or other activities due to her/his disability

_____ needs to take short breaks from class or other prolonged tasks

_____ is not able to take a full course load of classes due to their disability

Please give rationale as to why student cannot attend class or other activities, if applicable:

Classroom:

_____ has difficulty focusing as a result of their disability

_____ is unable to simultaneously take notes and listen to what is being said

_____ is unable to engage peers or work collaboratively

Exams:

_____ becomes overly anxious in timed situations (more than typical)

_____ experiences uncontrollable intrusive thoughts when under pressure and/or anxious

_____ engages in repetitive ritual(s) when under pressure and/or anxious

_____ subvocalizes thoughts or statements when under pressure and/or anxious

Other Functional Limitations (Social, Housing, etc.) (Please fill in as necessary):

_____ ____

_____ ____

_____ ____

7. Please state any ***specific recommendations regarding academic accommodations*** for this student.

8. Please ***provide any additional information you feel is pertinent*** or may be of use in determining appropriate accommodations.

Provider Information

Provider Name (Print): ____

Provider Signature: ____

License or Certification #: _____________________________________ State: ____________________

Address: ____

Phone: ___________________________________ FAX: _______________________________________

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