



Psychiatric Conditions Only

UNT Office of Disability Access (ODA) Psychiatric Disability Documentation Form
(To be completed by a Qualified Healthcare Professional)

Student Name:

Student UNT ID number:

Date:

The above named student has requested reasonable accommodations based on a psychiatric disability at the University of North Texas. To determine eligibility, the UNT Office of Disability Access requires documentation from a qualified health care professional (Medical Doctor, Psychiatrist, Psychologist, etc.) not related to the student. This information will be used to determine eligibility for reasonable accommodations under the Americans with Disabilities Act of 1990 as Amended. Please provide the following information.

Name of Health Care Professional:

License #

Phone:

Address:

Please provide the DSM code and Standard Nomenclature for this student's condition:

Medical and Health Condition:

Psychosocial and Contextual Factors:

Functioning and Disability:

Date of Diagnosis:

Most recent date you examined/treated this student:

Is this student currently under your care? Yes No

If yes, how long?

Please list prescribed medications and their side effects:

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

Please check all relevant items below and add any brief notes to help in determining reasonable accommodations for this student.

	Criteria	Additional Notes
	Structured or Unstructured interviews with the student	
	Interviews with other persons	
	Behavioral Observations	
	Developmental History	
	Educational History	
	Medical History	
	Neuro-psychological testing. Date(s) of Testing	
	Psycho-educational testing Date(s) of testing	
	Standardized or Nonstandardized rating scales	
	Other (please specify)	

Please complete the following matrix which will be used to establish eligibility for reasonable accommodations. Attach any relevant medical records (e.g. medical/developmental history, psychological evaluation, etc.)

Students may still qualify for reasonable accommodations when the potential exists for a previously stable condition to worsen. Please complete the matrix to reflect those periods when the condition is **not** well controlled. Consider side effects of medications and other treatment(s) that may negatively impact life activities. Completion of this form has no bearing upon a student's future employability.

Life Activity Matrix	No Impact	Moderate Impact	Severe Impact	Don't Know
Memory				
Sleeping				
Eating				
Social Interactions				
Caring for Self				
Managing Internal Distractions				
Managing External Distractions				
Timely submission of assignments				
Sustaining focus				
Making/keeping appointments				
Stress Management				
Organization				
Concentration				
Communication - Expressive				
Communication - Receptive				
Attending Class regularly				
Attending Class on time				
Other				

Based upon the limitations noted above, please list any recommendations for reasonable accommodations you may have.

By signing below, I am certifying that I or my designee has completed this form truthfully and accurately.

Signature and Professional Title:

Date:

Submit documentation via fax (940.369.7969), email Apply.ODA@unt.edu, deliver in person to Sage Hall Suite 167, or mail to 1155 Union Circ. #310770 Denton, TX 76203