



Disclosure Form – Psychiatric Disorders Information for clinicians

You are receiving the attached Disability Disclosure Form – Psychiatric Disorder - because a student under your care is requesting accommodations from the Disability Resource Center (DRC) at Northeastern University.

A diagnosis of a psychiatric disorder does not, in and of itself, qualify a student for accommodations under the ADA. Accommodations are not based on the student's diagnosis, but instead are designed to address the barrier(s) caused by any substantial limitation(s) related to the disorder. Accommodations are meant to allow full participation in academic and university life for students with disabilities; they do not guarantee student success. The DRC uses a multi-source process to determine eligibility for disability-related accommodations, which includes self-report, history of accommodations (when available), and clinical observations. This form is intended to provide us with the latter.

Please note that the information you provide in response to the questions on this form must be current; in general, you must have seen the student within the last 6 months to meet this requirement. If you have recently begun treating this student, you may find that you do not yet have sufficient information to respond to the questions on this form. If you have not had recent clinical contact with the student, or otherwise find that you cannot effectively complete this form, please inform the student directly.

If you have questions or concerns about this form, how the information is used, or how best to support the student, we invite you to contact our office, at 617.373.2675 or email DRCDocumentation@northeastern.edu.

* Students whose primary diagnosis is ADHD are asked to submit the Disability Disclosure Form – ADHD as well as neuropsychological or psycho-educational testing, if available. **Please do not use the Disability Disclosure Form – Psychiatric Disorder for students whose primary diagnosis is ADHD.**



Disclosure Form – Student authorization to clinician

Dear _____:
Clinician name

I am requesting accommodations from the Disability Resource Center (DRC) at Northeastern University. One element of the process for requesting accommodations is the submission of the Disclosure Form by my treating clinician. The Disclosure Form is attached, along with an explanation of its use and instructions for completion.

- I hereby authorize you to complete the attached Disclosure Form and release it to the DRC.
- I also authorize you to speak with the staff of the DRC to provide consultation concerning the requested accommodations.

Please submit the completed form by mail to:

Disability Resource Center
20 Dodge Hall
Northeastern University
360 Huntington Avenue
Boston, MA 02115

Or by confidential fax: 617-373-7800 or email DRCDocumentation@northeastern.edu

Thank you for your timely assistance with this matter.

Sincerely,

Student Signature

Date

Print Name

NU ID#



Disability Disclosure Form – Psychiatric Disorder

This form is to be filled out by the clinician currently treating the student for the diagnosis (es) identified below. Please read the attached “Information for clinician” cover sheet before completing this form

1. Patient’s/Client’s name: _____

2. Diagnosis: _____

3. Please provide full DSM or ICD-10 code: _____

4. Initial date of diagnosis: _____ Date of last clinical contact: _____

5. What is the frequency of the disorder’s symptoms for this student?

- Ongoing
- Episodic (Please Indicate frequency and duration) _____

6. The extent of the impairment is: Mild Moderate Severe

7. Assessment

How did you arrive at the diagnosis? Please check the relevant options below.

- Structured or unstructured interview with the student
- Interviews with other persons (parent, instructors, etc.)
- Behavioral observations
- Neuropsychological testing (please attach results)
- Rating scales (please attach results)
- Other (please name):

8. Please describe the student’s history of difficulties with his/her disability. Please include both general and academic areas of impact.

9. Treatment:

Please describe the current treatment and medication regimen. *Please include information about any significant medication side effects the student is experiencing, including sedation, diminished concentration, restlessness, thirst or dry mouth, nausea, frequent urination, light-headedness, dizziness, or headache*



10. Substantial limitations affecting academics

To aid in our determination of whether the student is substantially limited in the academic setting, we ask that you provide information about how the student’s symptoms impact him/her on tasks including, but not limited to:

*paying attention to lecture · taking notes · responding to questions · taking exams
participating in group work · following instruction · organizing work*

Please check those areas in which the student’s symptoms cause limitations, and provide a description of the impact experienced by the student on academic settings and tasks.

	<i>Area of substantial limitation</i>	<i>Please describe current impact on this student</i>
<input type="checkbox"/>	Concentration or attention	
<input type="checkbox"/>	Planning and organizing	
<input type="checkbox"/>	Processing speed	
<input type="checkbox"/>	Memory	
<input type="checkbox"/>	Learning	
<input type="checkbox"/>	Other:	
<input type="checkbox"/>	Other:	



11. Substantial limitations affecting campus life

To aid in our determination of whether the student is substantially limited in areas outside of academics, we ask that you provide information about how the student’s symptoms impact him/her in campus life (e.g., residence halls, peer interactions). Please consider, as relevant, the influence on tasks including, but not limited to:

self/personal care · interactions with roommates/peers · stamina and fatigue

Please check those areas in which the student’s symptoms cause limitations, and provide a description of the impact experienced by the student on non-academic settings and tasks.

	<i>Area of substantial limitation</i>	<i>Please describe current impact on this student</i>
<input type="checkbox"/>	Emotional regulation	
<input type="checkbox"/>	Sleeping	
<input type="checkbox"/>	Social functioning	
<input type="checkbox"/>	Stamina	
<input type="checkbox"/>	Other:	
<input type="checkbox"/>	Other:	



12. Additional information

Please provide any additional information you think will be helpful in determining reasonable accommodations for this student.

13. Annual update

You may be asked to update this form annually in order to confirm that the student continues to meet the diagnostic criteria for the given diagnosis(es) and to experience the substantial limitations described here. If your assessment of the student suggests that the condition is stable and will not require updates, please explain here:

14. Certification

Clinician's name: _____

Clinician's state licensure/certification #: _____

Area of specialty: _____ Clinician's phone #: _____

Clinician's signature

Date