BOSTON UNIVERSITY

Disability & Access Services

Disability Verification Form – Psychiatric Disabilities

The Disability & Access Services (DAS) provides academic accommodations and services to students with **Psychiatric Disabilities**. Students seeking accommodations must provide appropriate documentation of their disability so that Disability & Access Services can determine the student's eligibility for accommodations; and if the student is eligible, determine appropriate academic accommodations. The documentation must describe a disabling condition, which is defined by the presence of significant limitations in one or more major life activities.

To verify the disability and its severity, DAS requires the following current documentation from a physician or other approved specialist with experience and expertise in the area related to the student's disability.

Documentation should include:

- A **current** clear statement of disability including diagnosis and **DSM-5 or ICD Diagnosis (text and code)** and information concerning **co-morbidity**
- Documentation must be current, not more than one year old. In some cases documentation may need to be provided every six months, depending on the fluid or static state of their disability.
- **Current Functional Limitations:** Information concerning the **impact** of the disability on **major life activities** as well as the **functional limitations** and how they currently interfere in the educational setting. Again, factors to consider include the severity, duration, and pervasiveness of symptoms.
- A narrative **clinical summary** of assessment procedures that were used to make the diagnosis, evaluation results, and list any recommended accommodations. Summary must include psychiatric history.
- Suggested accommodations to address each limitation as well as history of accommodations used.
- The diagnostic report must include the ***name, and title, and license number*** of the evaluator.
- The evaluation and documentation much have been conducted by a licensed psychiatrist, neuropsychologist or other qualified and licensed mental health or medical professional.
- A **complete** Disability Verification Form (please do not write "see attached")

Please note: all appropriate documentation must be received prior to formal review process commencing. Also please be aware that provision of accommodations in High School, other non BU academic institution or on any standardized test does not guarantee that the same or any accommodations will be awarded at Boston University.

All documentation is considered confidential and can be mailed or faxed to:

Disability & Access Services
25 Buick Street Suite 300
Boston, MA 02215
Phone: 617-353-3658
Fax: 617-353-9646
access@bu.edu
www.bu.edu/disability

Boston University Disability & Access Services

Disability Verification Form – Psychiatric Disabilities

This form is intended to assist your client in meeting the documentation requirements for requesting academic accommodations on the basis of **Psychiatric Disabilities** at Boston University. Please fill out all of the questions on the below form, even if the material has been included in your full evaluation and/or clinical summary. The documentation must describe a disabling condition, which is defined by the presence of significant limitations in one or more major life activities.

Documentation must be current, not more than one year old. In some cases documentation may need to be provided every six months, depending on the fluid or static state of their disability.
Please include a copy (including test scores) of any relevant adult normed psychoeducational or neuropsychological reports. All information will be kept confidential. Please feel free to contact DAS at (617)353-3658 with any questions.

PLEASE NOTE: If you do not have current testing please refer to the to our documentation guidelines at: http//:www.bu.edu/disability.

Student name:
Signed:_____Date:_____
Name: (please print)_____ BU ID:_____

For the current treating healthcare provider to complete:

1. Please list all DSM-5 or ICD Diagnoses (text and code):

Diagnoses_____

a. Date diagnosed: _____
b. Date of your last clinical contact with student: _____
c. Current severity: _____

2. Evaluation

a. How did you arrive at this diagnosis? Please check all relevant items below, adding brief notes that you think might be helpful to us as we determine eligibility for accommodations.

O Structured or unstructured interviews with student.
O Interviews with other persons (i.e. parent, teacher, therapist).
O Behavioral observations.
O Neuropsychological testing. Attach documentation.
O Psychoeducational testing. Attach documentation.
O Other (Please specify). _____

b. Date of last evaluation _____

3. Functional Limitations: Y ☐ N☐ If yes, please describe: _____

_____

_____

a. Please describe in detail any functional limitations that fall into the significant range.

_____
_____
_____
_____

b. Please list current medications and treatment history.

_____
_____
_____
_____

c. Special considerations, e.g. medication side effects:

_____
_____
_____

4. **Coexisting Conditions**

Please provide details about any coexisting psychiatric conditions.
Please include all relevant reports.

_____
_____
_____

5. Past Accommodations

Please mark whether student has utilized accommodations in the past. Y ☐ N☐
Please describe:_____

_____
_____

6. Suggested Accommodations

Please list the specific academic accommodations you suggest based on your assessment of the students clinical and academic history and diagnosis. _____
_____
_____
_____

7. (Optional) Please provide any additional information you feel will be useful in determining the nature and severity of the student's disability, and any additional recommendations that may assist in determining appropriate accommodations and interventions:

_____
_____
_____

Thank you for your help in providing this information so that we may begin services as soon as possible. Please complete the provider information below. This form should be signed and returned to DAS at the address shown at the end of this document.

- **PLEASE NOTE:** To provide documentation of Psychiatric Disabilities, the evaluation must have been conducted or formally supervised by a licensed psychiatrist, neuropsychologist or other qualified and licensed mental health or medical professional.

Provider Information
I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

If filling out online, in lieu of signature, please click here to certify that the above statement is true.
Y ☐ N☐

Signature: _____ Date: _____

Print Name and Title: _____

State of License_____: License Number: _____

Address: _____

Street or P.O. Box City State Zip: _____

Phone: _____Fax:_____

Please return this signed form to:
Disability & Access Services,
25 Buick Street Suite 300
Boston, MA 02215
Phone: 617-353-3658
Fax: 617-353-9646