



VCU

Student Accessibility and
Educational Opportunity
Student Affairs

PSYCHOLOGICAL/PSYCHIATRIC DISABILITY VERIFICATION FORM

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Richmond, VA 23284
Phone: (804) 828-2253
Email: saeo@vcu.edu
Website: www.saeo.vcu.edu

1. IDENTIFYING INFORMATION

Student's Name _____

V Number _____

Student's Email _____

@vcu.edu

Student's Phone _____

2. TO BE COMPLETED BY A LICENSED MEDICAL PROFESSIONAL

A. Diagnostic Information

A1. DSM-V Diagnosis: _____

Primary: _____

Secondary: _____

A2. Date of Diagnosis: _____

A3. In addition to the DSM-V criteria, how did you arrive at your diagnosis? Please check all relevant items below, adding brief notes that you think might be helpful to us as we determine which accommodations and services are appropriate for the student:

√	Criteria	Notes (please add information to a checked area)
<input type="checkbox"/>	Structured or unstructured interviews	
<input type="checkbox"/>	Interviews with other persons	
<input type="checkbox"/>	Medical tests	
<input type="checkbox"/>	Medical history	
<input type="checkbox"/>	Behavioral observations	
<input type="checkbox"/>	Developmental history	
<input type="checkbox"/>	Psychological testing	
<input type="checkbox"/>	Other (please specify)	

B. Contact History

B1. This student has been under a provider's care for this issue since: _____

B2. Date student was last seen: _____

C. Impact of Condition

C1. How long is this condition likely to persist? (Permanent/Temporary) _____

C2. How often is the student required to check-in with a provider?

- Once a week Once a month Every 3-4 months Every 6 months
 Once a year As needed Other: _____

C3. Is the student currently taking medication(s) for their symptoms?

- YES NO

If yes, what medication(s) is the student currently taking? For each medication, describe the side effects and any impact on academic performance. Do limitations/symptoms persist even with medications?

Medication and Dosage	Side Effects	Academic Impact	Symptoms Persist with Medication?

C4. Please note to what extent each of the following major life activities are affected due to the diagnosis.

1 – Unable to Determine 2 – No Impact 3 – Mild Impact 4 – Moderate Impact 5 – Substantial Impact

Major Life Activities	1	2	3	4	5
Caring for oneself					
Talking					
Hearing					
Breathing					
Seeing					
Walking					
Standing					
Lifting/Carrying					
Sitting					
Performing manual tasks					
Eating					
Working					
Interacting with others					
Sleeping					

Learning/Time Management	1	2	3	4	5
Reading					
Writing: composition					
Writing: spelling					
Math (quantitative reasoning)					
Processing speed					
Stress management					
Listening					
Concentration					
Managing distractions					
Memory					
Planning/Organization					
Time management					
Attending classes regularly					
Timely submission of assignments					

C5. What other specific symptoms manifesting themselves at this time might affect the student’s ability to access VCU’s programming, facilities, and/or academic opportunities?

C6. What is the student’s prognosis? How long do you anticipate that the student’s ability to access VCU’s programming, facilities, and/or academic opportunities will be impacted by their disability/condition?

C7. Have there been any changes in the student's condition in the past 12 months?

- YES (please explain below) NO

C8. Do you anticipate any changes in the student's condition in the next 12 months?

- YES (please explain below) NO

C9. Is there anything else you think we should know about the student's medical condition and their ability to function academically and/or socially in a college environment?

D. Credentials and Signature

PLEASE TYPE OR PRINT CLEARLY

Name and Title

Professional Qualifications

Address

City

State

Zip Code

Phone

Fax

Signature

Date