UCSF Student Disability Services
Student Academic Affairs

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StudentDisability@ucsf.edu | sds.ucsf.edu

VERIFICATION OF PSYCHOLOGICAL DISABILITY

Student Name____Birthdate:____________

I am requesting academic support services through the Student Disability Services (SDS) at UCSF. They require current and comprehensive documentation of my psychological condition as one of the criteria used to evaluate my eligibility for disability related accommodations or services. Please respond to the following questions as soon as possible and return to me or send to SDS by mail or fax. I authorize the Student Disability Services at UCSF to contact you if clarification is needed.

Student Signature____Date________________

Mental Health Provider name (print) ____

Title ____

Phone _________________________________ Fax____________________________________

Organization & address ____

The area below must be completed by the Health Care Professional listed above.

1. What it the psychological diagnosis using the DSM IV and/or DSM V:

If using the **DSM-IV** please code on five axes:

Axis I ____

Axis II ____

Axis III ____

Axis IV ____

Current GAF__________

If using the **DSM-V** please list the diagnoses with the principle diagnosis being listed first, and others following in order of importance to treatment:

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2. What were the assessment or evaluation procedures used to make the diagnosis? And what (if any) historical data was taken into account in making the diagnosis?

3. What medications are prescribed currently? List any side effects and level of severity.

4. Please indicate the major symptoms of the disorder currently manifested by the student, including the level of severity:

SYMPTOM	**LEVEL OF SEVERITY**				
	Mild		Moderate		Severe
____________________________________	1	2	3	4	5
____________________________________	1	2	3	4	5
____________________________________	1	2	3	4	5
____________________________________	1	2	3	4	5

5. Is the individual currently in treatment with you? When did treatment start and how often?

6. What is the prognosis and anticipated duration?

7. What are the current limitations imposed by this disorder?

8. Recommendations**:** If you are recommending accommodations, please do so within your area of expertise. (e.g. Human Animal Interaction Counseling, Learning Disability Specialist, etc.)

Signature of Treatment Provider ____________________________________

License # ______________________ **Date** ______________________

Thank you for your cooperation. You may email your report to SDS at StudentDisability@ucsf.edu. Please call (415) 4762 6595 if you require additional information. Please attach any additional reports or relevant information. *All information on this form will remain private in conjunction with FERPA (Family Education Rights and Privacy Act)*