Information for Students Seeking Accommodations for Psychological Conditions

UC Davis is committed to ensuring equal access to educational opportunities for students with disabilities. The Student Disability Center (SDC) has been delegated responsibility for authorizing academic accommodations for students with disabilities and coordinating individualized academic support services.

Eligibility

A student who seeks SDC services for a psychological condition must submit current and complete documentation of a psychological condition from a qualified professional. Current documentation is required to assess whether the student has an impairment that limits a major life activity and to establish if the student has functional limitations in an academic setting that require accommodations. Documentation of the functional limitations, including a description of the student's compensatory strategies, determines the nature of the reasonable academic accommodations that a student may receive. A description of both functional limitations and compensatory strategies is critical to providing disability management services and assisting the student in developing skills and strategies for academic success, independence, and self-determination.

Qualified diagnosing professionals include licensed clinicians whose scope of training and experience include diagnosis and treatment of adults with psychological disabilities (e.g., licensed Psychologists, Physicians, Marriage and Family Therapists, and Clinical Social Workers). The diagnosing professional must have expertise in the differential diagnosis of the documented psychological condition and follow established practices in the field.

An individualized, complete and current description will benefit the student and aid in the process of determining accommodations. Complete documentation consists of a comprehensive report provided to the SDC by a qualified diagnosing professional and should contain the information covered in the attached questionnaire, including the following:

1) Date of the most recent visit to the diagnosing professional
2) Primary and additional/secondary diagnoses
3) Basis for the diagnosis (including data from tests, clinical interviews, school history, etc.)
4) Description of any diagnosed psychological conditions, their severity, treatment, and prognosis
5) Description of any current functional limitations that are a direct result of the psychological condition, and the impact of these limitations on the student’s ability to perform academic tasks.

6) Statement of the extent to which functional limitations are mitigated by current treatment (including medication) and/or compensatory strategies used by the student.

Additional documentation may be requested when necessary.

**Accommodations and Support Services**

Requests for accommodations are considered on an individual basis based on the student’s documented current functional limitations in the context of course requirements and the student’s academic program. The student is responsible for submitting documentation of the disability. After establishing eligibility, the student must submit requests for accommodations to the SDC each quarter and, once the requests are approved, contact each instructor to arrange logistics for exam/classroom accommodations. If the student has questions or concerns about the accommodations, please contact the SDC right away.

**Mailing Address and Contact Information**

Student Disability Center • University of California

One Shields Avenue • Room 54 Cowell Building • Davis, CA 95616

sdcrequests@ucdavis.edu • (530) 752-3184 voice • (530) 752-0161 fax
# Psychological Condition Questionnaire

**Student Name:** ________________  **Student ID #** ________________  **Birthdate:** ________________

This request for information about my psychological condition is being provided to you in connection with my application for academic support services from the Student Disability Center ("SDC") at the University of California, Davis. The SDC requires current and comprehensive documentation of my psychological condition from a “qualified diagnosing professional” as part of (1) the SDC’s evaluation of whether I am eligible for SDC services based on disability and, if so, (2) the SDC’s determination of appropriate academic adjustments based on functional limitations resulting from my condition. “Qualified diagnosing professionals” include licensed clinicians whose scope of training and experience include diagnosis and treatment of adults with psychological disabilities (e.g., licensed Psychologists, Physicians, Marriage and Family Therapists, and Clinical Social Workers). Please respond to the following questions as soon as possible and return to the SDC by fax (530-752-0161) or email (sdc@ucdavis.edu).

By signing the attached release, I authorize the SDC to contact you if clarification is needed.

**Student Signature** _______________________________________________  **Date** _____________________

**Mental Health Provider Name (Print)** ______________________________________________________________

**Title:** ___________________  **License #** ___________________  **State** ________________

**Phone:** ___________________  **Fax:** ___________________

The following questions are to be answered by the qualified professional identified above. Note: if you have insufficient information to respond to one or more of the questions, please state that below:

If you feel you cannot provide documentation for this student, please indicate the reason below:

- ____ I am not treating this student
- ____ I have referred to another clinician
- ____ I would need additional sessions with the student to complete this form
- ____ I have insufficient information to describe functional limitations that would impact the student’s academic work
- ____ Other ____________________________________________

1. What are the primary and secondary diagnoses for this student?

   ____________________________________________________________________________________

   **Initial date of diagnoses:** ______________________________

   **A.** Is the student currently receiving treatment under your care?  **YES** ___  **NO** ___

   If yes, dates of treatment within the last six months: ________________________________

   **B.** If you know, please indicate whether this student is currently receiving psychological treatment for her/his condition. **YES** ___  **NO** ___  If yes, please describe: ________________________________

2. What assessment or evaluation procedures were used to make the diagnosis? Include copies of educational/medical history and/or neuropsychological or psychoeducational reports.

   [ ] Interview with the student  [ ] Behavior Observations  [ ] Medical History /Structured Intake

   [ ] Neurological Testing; **Dates:** ________________________________

   [ ] Psycho-educational Testing; **Dates:** ________________________________

   [ ] Rating Scales; **Specify:** ________________________________

   [ ] Other; ____________________________________________________________
3. What historic data was taken into account in making the diagnosis? Include copies of educational/medical history.

[ ] Developmental History
[ ] Educational history
[ ] Review of Prior Treatment Records
[ ] Other Record Review; Specify:

[ ] Consultation with Other Clinicians; Specify:

4. Describe student’s current and specific functional academic limitations resulting from the condition, including results of evaluations (e.g., neuropsychological tests of processing speed), documenting specific limitations:

A. Limitation: __________________________________________

Level of Severity (without treatment)  Mild  Moderate  Severe
1  2  3  4  5

Level of Severity (with treatment)  Mild  Moderate  Severe
1  2  3  4  5

B. Limitation: __________________________________________

Level of Severity (without treatment)  Mild  Moderate  Severe
1  2  3  4  5

Level of Severity (with treatment)  Mild  Moderate  Severe
1  2  3  4  5

If additional space is needed, please add separate sheet.

5. What is the prognosis and anticipated duration of the limitations? ________________________________

For how long are current limitations/diagnoses valid as basis for postsecondary academic adjustments?

When do you recommend a clinical follow-up or re-evaluation of the condition? ______________

6. What compensatory strategies do you recommend and/or does the student use to mitigate the impact of the psychological condition? (e.g. anxiety-reduction techniques, time-management strategies, etc.)

____________________

7. Describe side effects from medications currently used by the student, including impact on functional limitations:

A. Is the student compliant with the medical treatment plan? YES____  NO ____ If not, please explain how non compliance impacts the student’s limitations: ________________________________

8. Other concerns, findings, or clinical recommendations: __________________________________________

Signature of Treatment Provider: ____________________________________________________________

Date: __________________________

Printed Name: __________________________ License # __________________ State: __________

Revised April 30, 2013