Information for Students with Psychological Disabilities

UC Davis is committed to ensuring equal access to educational opportunities for students with disabilities. An integral component in the implementation of that commitment is the coordination of academic accommodations and support services through the Student Disability Center.

Eligibility

To determine eligibility for services, the SDC requires current and complete documentation of a psychological disability from a qualified professional. The University reserves the right to request supplemental information to verify a student’s current functional limitations. Current documentation is required to describe whether the disability limits a major life activity and to establish the extent of the student’s disability-related, academic limitation.

Qualified diagnosing professionals include licensed psychologists, psychiatrists, neurologists, licensed therapists, or in some instances, general practice physicians. The diagnosing professional must have expertise in the differential diagnosis of the documented mental disorders and follow established practices in the field.

The report must be signed by the licensed diagnosing professional.

Complete documentation consists of a comprehensive report provided to the SDC by a qualified diagnosing professional containing ALL of the following information:

- Date of the most recent visit to the diagnosing professional
- Primary and additional/secondary diagnoses
- Basis for the diagnosis (include data from tests, clinical interviews, school history, etc.)
- Description of any diagnosed psychological disorders, their severity, treatment, and prognosis
- Assessment of any current, related medication issues and their extent
- Description of any current functional limitations, as a direct result of the disorder, and the academic impact of these
- Statement of the extent to which any functional limitations are mitigated by current treatment (including medication)

Additional documentation may be requested when necessary.

Accommodations and Support Services

Request for accommodations are considered on an individual basis based on the student’s documented, current functional limitation 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, each quarter the student must request accommodations utilizing the online Student Portal (https://sdc.ucdavis.edu/). Once the request has been made it is advised that the student contact each instructor to confirm arrangements and logistics for exam/classroom accommodations. If the student has questions or concerns about the accommodations, please contact your assigned SDC specialist.

Contact Information

Joseph Spector, Ph.D.
SDC Psychologist & Disability Specialist
(530) 752-3184 voice
(530) 752-0161 fax
jmspector@ucdavis.edu
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
_____ 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

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