



State University of New York

# Upstate Medical University

Student Support Services

155 Elizabeth Blackwell Street, Syracuse, NY 13210

## Summary for Psychiatric Condition/Disability Documentation

### Student

Name: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

### Certifying Mental Health Professional

Name \_\_\_\_\_

Professional title \_\_\_\_\_ Highest degree \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_

Licensing credential, number and state \_\_\_\_\_

Report Date \_\_\_\_\_ Date of first student contact \_\_\_\_\_ Date of last student contact \_\_\_\_\_

DSM IV diagnosis (es):

Axis I \_\_\_\_\_

Axis II \_\_\_\_\_

Axis V \_\_\_\_\_

In your opinion, does any condition listed above *substantially limit a major life activity* and thereby rise to the level of disability? Yes \_\_\_ No \_\_\_ Not sure \_\_\_

If yes, indicate which one(s) with an asterisk above and indicate the major life activity(ies) here:

Brief History (Include onset of symptoms, hospitalizations, relevant family history, and any previous accommodations)

*Please continue to other side*

Symptoms that limit functioning (indicate degree of limitation for each – mild, moderate, severe):



Additional clinical commentary

\_\_\_\_\_  
In your opinion, how often should this student re-evaluated?

3 mos \_\_\_ 6 mos \_\_\_ 1 year \_\_\_ Other (specify) \_\_\_\_\_

Safety

In your opinion, does this individual represent a potential danger to self or others, *including patients under his or her care in a medical setting*? Yes \_\_\_ No \_\_\_ Not sure \_\_\_

If "yes" or "not sure," PLEASE DISCUSS above under clinical commentary or on attached letterhead.

Signature \_\_\_\_\_ Date \_\_\_\_\_