DISABILITY SUPPORT SERVICES - STUDENT SUCCESS CENTER
766 Irving Ave. • 130 Health Science Library • Syracuse, NY 13210
T: 315.464.8855 F: 315.464.5431 *stuserve@upstate.edu*

UPSTATE MEDICAL UNIVERSITY

SUMMARY FOR PSYCHIATRIC CONDITION/DISABILITY DOCUMENTATION

STUDENT

Name: Last: ______________________ First: ______________________ M.I.: ____________

Address: ____ Telephone #: (____) ______________

City: ______________________ State: ________ Zip: ______________ Date of Birth: ____ / ____ / ________

To be completed by a student's treating healthcare provider.

CERTIFYING MENTAL HEALTH PROFESSIONAL

Name ____

Professional title ____

Telephone #: (____) ______________ 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)*

____

____

____

____

____

____

19-0367 Rev. 10/2019 Review 10/2019

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

____

____

____

____

Recommended Accomodations ☐ Yes ☐ No

If yes, please specify and give a rationale for each recommendation:

____

____

____

____

Medication/treatment

Does this student take any medication(s) or require any type of treatment that may adversely affect performance or behavior? ☐ Yes ☐ No

If "yes," please list and explain effect:

____

____

____

Current compliance with treatment plan? ☐ Poor ☐ Good ☐ Excellent ☐ Unknown ☐ N/A

Current prognosis for functioning effectively at Upstate? ☐ Poor ☐ Good ☐ Excellent ☐ Unknown

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 ________________