GATEWAY TECHNICAL COLLEGE

Serving Southeastern Wisconsin since 1911

# Verification of Psychological Disability

The student named below has applied for services from the Special Needs Department at Gateway Technical College. In order to provide reasonable and appropriate services, current and comprehensive information regarding the functional impact of the disability is required. This form is intended to provide the Special Needs staff with sufficient information so that eligibility for services and appropriate accommodations can be determined. The information you provide is confidential and will not become part of the student's education record. In addition to the requested information, please attach any additional information you deem appropriate. Thank you for your assistance.

1. Name of student: _____ Date of Birth:_____
2. Date of your last contact with student: _____
3. What is the DSM-IV multi-axial diagnosis for this student?

   Axis I: _____

   Axis II: _____

   Axis III: _____

   Axis IV: _____

   Axis V: _____

4. Please list any medications that have been prescribed for this student:

   | Medication: | Date Prescribed: |
   |---|---|
   | _____ | _____ |
   | _____ | _____ |
   | _____ | _____ |

5. What methods or testing instruments did you use to arrive at your diagnosis? Please check all relevant items including brief comments that you think might be helpful to us as we determine appropriate accommodations for this student.
   - □ Structured or unstructured clinical interviews with the individual
   - □ Interviews with other individuals
   - □ Developmental history
   - □ Medical history
   - □ Psychological testing. Date(s) of testing? _____
   - □ Standardized or non-standardized rating scales
   - □ Other (please specify)

     _____

6. Please asses the degree of functional impairment due to the Psychological disability demonstrated by your patient.

**1 = Negligible 2 = Moderate 3 = Substantial 4 = Severe**

| | | | | | |
|---|---|---|---|---|---|
| 1) | Time Management | 1 | 2 | 3 | 4 |
| 2) | Organization Skills (physical and/or cognitive) | 1 | 2 | 3 | 4 |
| 3) | Concentration | 1 | 2 | 3 | 4 |
| 4) | Memorization | 1 | 2 | 3 | 4 |
| 5) | Reading (fluency, comprehension) | 1 | 2 | 3 | 4 |
| 6) | Quantitative Skills | 1 | 2 | 3 | 4 |
| 7) | Written Expression | 1 | 2 | 3 | 4 |
| 8) | Sleeping | 1 | 2 | 3 | 4 |
| 9) | Social Interactions | 1 | 2 | 3 | 4 |
| 10) | Information Processing | 1 | 2 | 3 | 4 |
| 11) | Self-care | 1 | 2 | 3 | 4 |
| 12) | Other _____ | 1 | 2 | 3 | 4 |

7. Please describe functional limitations this student encounters when using medication.

8. Please describe an appropriate intervention plan and indicate how the plan will be managed:

| **Treatment/Intervention** | **Provided** | **Needs Referral** |
|---|---|---|
| ➢ Pharmacology (treatment and medication) | □ | □ |
| ➢ Compensatory Strategies (please specify) _____ | □ | □ |
| ➢ Academic Study Skills (please specify) _____ | □ | □ |
| ➢ Brief Psychotherapy | □ | □ |
| ➢ Long-term Psychotherapy | □ | □ |
| ➢ Other (please specify)_____ _____ | □ | □ |

9. Is there anything else you would like us to know about this student?

_____ _____
Signature of Professional Date

_____ _____
Medical Professional's Name and Title (printed) License Number

_____
Address City State Zip

_____ _____
Telephone Number Fax Number