Student Accessibility Services

THE UNIVERSITY OF MAINE

Center for Accessibility
&Volunteer Engagement
139 Rangeley Road
Orono, ME 04469-5779
Tel: 207.581.2319
Maine Relay: 711
Fax: 207.581.9420
umaine.edu/studentaccessibility

DISABILITY DOCUMENTATION FORM

The student named below has requested accommodations from Student Accessibility Services (SAS) at the University of Maine. In order to determine eligibility and to provide accommodations, we require documentation of the student's disability.

This form is to be completed by the treating clinician, psychiatrist, social worker, or medical provider only. Forms completed by the student or parent will not be considered documentation of disability. Once completed it can be returned to us via email at um.sas@maine.edu, faxed at 207.581.9420 or regular mail. The information you provide will not be filed with the student's other educational records, but will be kept in the student's file at SAS, where it will be held confidential. In addition to the requested information, please attach any other information you think would be relevant to the student's accommodations. Please contact us if you have questions or concerns. Thank you for your assistance.

Student Name: _____ Date of Birth:_____

Today's Date: _____ Date of Diagnosis: _____

Date student was last seen: _____

Student is seen: ☐ Occasionally ☐Regularly ☐Only as needed

Please fill out all applicable sections below

DSM-5 Diagnosis:

_____

_____

ICD -10 Codes & Diagnosis:

_____

_____

What is the severity of the condition? Please check one: ☐ Mild ☐ Moderate ☐ Severe

Please explain: _____

_____

1. In addition to the DSM-5 / ICD-10 criteria, how did you arrive at your diagnosis? Please check all relevant items below, and *add a descriptive statement for each item checked*. This information will help us determine appropriate accommodations and services for the students.

☐ Structured or unstructured interviews with the person themselves:

☐ Interviews with other persons:

☐ Behavioral observations:

☐ Developmental history:

☐ Family history:

☐ Educational history:

☐ Medical history:

☐ Neuro-psychological testing. Please attach a copy of the testing.

☐ Psycho-educational testing. Please attach a copy of the testing.

☐ Standardized or un-standardized rating scales.

☐ Other (please specify):

2. **Major Life Activities Assessment:** Please check which of the following major life activities listed below are affected by the student's disability and indicate the severity of the limitations.

Life Activity	**No Impact**	**Mild Impact**	**Moderate Impact**	**Severe Impact**	**Don't Know**
Concentrating					
Memory					
Self-Care					
Speaking					
Learning					
Reading					
Communicating					
Sleeping					
Managing Internal Distractions					
Managing External Distractions					
Regular Class Attendance					
Meeting Assignment Deadlines					
Stress Management					
Organization					

3. ADD/ADHD Diagnosis and history: If student has a diagnosis of ADD/ADHD please describe evidence of inattention and/or hyperactivity currently and in years prior (e.g. difficulty sustaining attention in tasks or activities, difficulty with executive functioning, unable to sit still, difficulty following directions, impulsivity etc.).

_____

_____

_____

_____

_____

4. Is the student currently receiving therapy or counseling?
   ☐ Yes ☐ No ☐ Not sure

5. Please provide relevant information regarding the student's psychological, educational and medical history (e.g. poor grades in school due to problems with executive functioning, history of risk or dangerous activities, history of depressed mood etc.) and any specific symptoms/functional limitations that might affect the student in an academic setting.

_____

_____

_____

_____

_____

6. Has medication been prescribed or is treatment ongoing? Please any list current medication(s) that the student is prescribed including dosage, frequency of use, adverse side effects, and the effectiveness of the medication.

_____

_____

_____

_____

7. State specific recommendations regarding the academic accommodations for this student, and a rationale as to why these accommodations/services are warranted based upon the student's functional limitations. Indicate why the accommodations are necessary (e.g. if a note taker is suggested, state the reason for this request related to the student's diagnosis).

_____

_____

_____

_____

_____

_____

HEALTHCARE PROVIDER INFORMATION

(Please sign & date below and completely fill in all other fields)

Provider signature: _____ Date: _____

Provider Name (Print): _____

Title: _____ License: _____

Address: _____

_____

Phone Number (_____) _____ - _____

Fax Number (_____) _____ - _____

Email Address: _____