Disability Resources
RM 139, Donaldson Campus
406.447.6952

# Psychiatric Disability Documentation Form

I _____ authorize _____ to release information
(name of student) ( physician/therapist)
related to my disability to the Office of Disability Resources at Helena College University of Montana. I also grant Disability Resources permission to clarify answers about my disability via additional oral or written communications.

Signature: _____ Date: _____

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Dear Medical Provider:

The disability services staff at Helena College needs documentation about this student's disability to determine disability eligibility and to facilitate educational accommodations and/or assistance as soon as possible. A note on a prescription pad is not sufficient. It is often difficult to determine appropriate accommodations without understanding the disability or physical condition that has been identified, as well as the impact on the student's daily functioning, the treatment plan, and the follow-up plan.

Date of Diagnosis: _____

1. DSM 5

Axis I: _____ Description: _____
Axis II: _____ Description: _____
Axis III:_____ Description: _____
Axis IV:_____ Description: _____
Axis V: _____ Description: _____

What diagnostic instruments were used for this diagnosis?

Please comment on other diagnoses that have been considered and ruled out, including substance abuse and learning disabilities.

2. Does this condition significantly limit one or more of the following major life activities?

Walking Hearing Seeing Sleeping Working

Manual Tasks Learning Performing, specify _____

Other: _____

3. Describe the functional limitations and/or behavioral manifestations (e.g. easily distractible, poor concentration, difficulty focusing for extended periods of time, difficulty formulating and executing plan of action, difficulty overcoming unexpected obstacles, panics in unfamiliar surroundings and situations, etc.) and recommended educational accommodations:

| Behavior | Recommended Accommodation |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

4. Is there a current medication treatment plan? Yes ____ No ____ n/a ____
Is there a current counseling treatment plan? Yes ____ No ____ n/a ____

5. Special considerations, e.g. medication side effects: _____

_____

6. Recommended re-evaluation time period or date: _____

**Your name, title and credentials**:

Signature: _____ Date: _____

Please send this documentation to:

Office of Disability Resources
Helena College University of Montana
1115 North Roberts
Helena, MT 59601
Email: disabilityresources@helenacollege.edu
Phone: (406) 447-6952 Fax: (406) 447-6397