Psychiatric Disability Verification Form
East Carolina University
Disability Support Services
Dss.dept@ecu.edu, fax: 252-737-1025, 252-737-1016

Student Information

Name: _____

Date of Birth: _____ Student ID: _____

The following information needs to be filled out by a qualified provider. Please provide responses to the following items by typing or writing clearly. Illegible forms will delay the documentation review process for the student.

Provider Information

Provider Signature: _____ Date: _____

Provider Name (print): _____

Title: _____

Address: _____

Phone: (_____) _____ Fax: (____) _____

1. Date of Diagnosis: _____
2. Date student was last seen: _____
3. DSM-V Diagnosis

   _____

   _____

4. **If a psycho-educational evaluation was completed, please include with this form.**

5. What is the expected duration of this disability? _____
6. Is the student currently taking medications? If so, how might side effects, if any, affect the student's academic performance?

Major Life Activities: Please check which of the following major life activities are affected and the degree to which they impact the student.

Life Activity	No Impact	Moderate Impact	Substantial Impact	Don't Know
Concentrating				
Memory				
Eating				
Sleeping				
Self Care				
Social Interactions				
Ability to Pay Attention				
Attending Class Regularly				
Managing internal distractions				
Managing external distractions				
Stress Management				
Organization				
Attending to Tasks				
Putting Thoughts to Words				
Motivation				

7. Please describe symptoms relating to this diagnosis that may affect the student's academic performance and/or housing accommodations.

_____

_____

_____

_____

8. Please state specific recommendations regarding academic accommodations for this student.

_____

_____

_____

_____

9. Are there other associated disabilities? If so, what are they? Please describe these conditions and any functional limitations.

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