

**ALBION COLLEGE**

**Verification of a Psychiatric/Psychological Disability**

**The Learning Support Center provides services to students with diagnosed psychiatric disabilities. To determine eligibility for services, this office requires current comprehensive documentation of the disorder for the diagnosing psychiatrist, psychologist or other licensed professional. Information shared with our office is confidential and all records are housed in the center and are not part of the student's academic record. To assist our office in providing appropriate support for your patient, please answer the following questions.**

**Student name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**DSM diagnosis:**

**Axis I** \_\_\_\_\_

**Axis II** \_\_\_\_\_

**Axis III** \_\_\_\_\_

**Date of Diagnosis:**

**Describe the symptoms that meet the criteria for this diagnosis. Please indicate any changes in symptoms since diagnosis.**

**Is there any indication that the patient may have additional diagnosis, i.e., ADHD, learning disability, etc?**

**List current medications(s), dosage, frequency and adverse side effects. Has the patient adhered to the medication treatment?**

**What is the current treatment plan for the patient in addition to medication? What is the expected duration? If treatment requires absence from campus, please indicate frequency and length of time required.**

**Indicate possible functional limitations your patient may experience in the following areas:**

**Living Arrangements:**

**Social Interactions:**

**Daily academic activities:**

(Examples include maintaining attention in class, completing assignments, etc.)

**Exams:**

(Examples include completing exams, memory, anxiety, distractibility, etc.)

**Other:**

**Please indicate accommodations that may be helpful for your patient. Each recommendation should include an explanation of its relevance to the diagnosis or area of functional limitation.**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Print name and title:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone** \_\_\_\_\_ **Email** \_\_\_\_\_

**Return this information to the Learning Support Center, Albion College, Albion Michigan 49224**

**Release of Information**

**I, \_\_\_\_\_, hereby authorize the exchange and release of information to the Learning Support Center of Albion College for the purpose of determining my eligibility for educational accommodation.**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Student's signature**