STOCKTON UNIVERSITY | WELLNESS CENTER

Learning Access Program
Documentation of Diagnosed Disability

Student Name_____ Z# _____

The above named student has indicated that you are the physician, psychiatrist, social worker, or mental health provider who has conducted and/or supervised their diagnostic assessment. To help us determine eligibility and evaluate the request for accommodations, please answer the questions below:

1. **Diagnosis:** (please list all relevant diagnoses and co-existing conditions according to DSM 5 and/or ICD-10)

_____

Date of your last clinical contact with student: _____/_____/_____

2. **Evaluation**: How did you arrive at this diagnosis?

- ◯ Behavioral observations
- ◯ Medical evaluation
- ◯ Neuropsychological testing (attach documentation)
- ◯ Psychoeducational testing (attach documentation)
- ◯ Structured or unstructured interview with student
- ◯ X-ray, CAT Scan, and/or MRI
- ◯ Other exam: Specify _____

Evaluation results: _____

_____

3. **Treatment:**

◯ Medication management

Current medications: _____

_____

Special Considerations, e.g. medication side effects: _____

_____

◯ Physical/Occupational therapy frequency: _____

_____

◯ Other (please describe): _____

_____

4. **Functional Impact** (please describe the current impact of the disability and indicate specific major life activities/major bodily functions):

Major Life Activities: Include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communication, and working.
Major Bodily Functions: Include, but are not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

_____

_____

_____

5. **Past Accommodations** (please indicate previous accommodations if applicable):

_____

_____

6. **Suggested Accommodations** (please list the specific accommodations you suggest based on your assessment of the student's diagnosis):

_____

_____

7. **Additional Information** (Optional):
Please provide any additional information you feel will be useful in determining the nature and severity of the student's disability, and additional recommendations that may assist in determining appropriate accommodations and interventions.

_____

_____

Thank you for taking the time to complete this form. If we need additional information we may contact you at a later date. The physician, psychiatrist, social worker, or mental health provider that completed this form must sign and date below and provide either the provider stamp or a copy of business card. Please return the completed document via fax to 609.626.5550 or by email to lap@stockton.edu.

Provider Stamp or Business Card Required

Signature: _____ Date: _____/_____/_____

License # _____