



Disability Disclosure Form – Psychiatric Disorder

Date: _____

Dear (Clinician Name) _____ :

I am requesting services from the Disability Resource Center (DRC) at Northeastern University. In order to receive services, the DRC requires documentation of my disability. Services at the DRC are solely based on diagnostic documentation. Once this information is in place, it will be used to develop a service plan for me.

- I hereby authorize you to complete the enclosed Disclosure Form and release it to the DRC.
- I also authorize you to speak with my DRC Specialist in consultation to provide future services.

**Please submit the completed form to:
Ms. Debbi Auerbach, Service Coordinator**

By mail:
Northeastern University
Disability Resource Center
20 Dodge Hall
360 Huntington Avenue
Boston, MA 02115

By confidential fax: 617-373-7800

You may contact Ms. Auerbach with any questions (phone: 617-373-2675 / TTY: 617-373-2730 or email: d.auerbach@neu.edu).

Thank you for your timely assistance with this matter.

Sincerely,

Student Signature

Date

Print Name

Medical Record ID#



Disability Disclosure Form – Psychiatric Disorder

This form must be completed by the licensed clinician or health care provider **who is treating this patient for the diagnosis identified** in this document. *In order to best serve the student, please thoroughly complete all requested information.*

Patient’s/Client’s Name: _____

Clinician’s Name: _____

Clinician’s State Licensure/ Certification #: _____

Area of Specialty: _____ **Clinician’s phone #:** _____

The person named on this form is requesting services from the Disability Resource Center. The DRC offers services to students who are considered disabled under the mandates of the Americans with Disabilities Act As Amended of 2008 (ADAAA). Under the ADAAA definition, a person with a disability is one with a physical, mental, emotional or chronic health impairment that substantially limits one or more major life activity such as caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. Major life activities also include bodily functions relating to the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproduction (*this is not an exhaustive list*).

I verify that the person named in this document has a substantially limiting disorder that meets the aforementioned ADAAA disability criteria: Yes No

If **yes**, please thoroughly complete this form to document the substantial limitations that are linked to this disability.

▪ **Diagnosis/Description of Disability:** _____

▪ **Please provide full DSM or ICD-9 code:** _____

▪ **Initial Date of Diagnosis:** _____ ▪ **Date of last clinical contact:** _____

- **Expected duration of disability noted above is:**
 - Permanent
 - Short term (60-90 days)
 - Chronic
 - Temporary (1-60 days)
 - Long term (3-12 months)



- **The extent of the disability is:** Mild Moderate Severe

- **What is the frequency and duration of symptoms of the student's condition?**
 - Daily 1x/week 1-3x/week 1x/month 1-3x/year Seasonal
 - None – symptoms under control with medication Other: _____

- **Assessment Instruments and Results** (Please describe the procedures, assessment tools, etc. used to establish the diagnosis):

- **Please describe the functional impact of the disability/symptoms on this individual's:**
 - Daily life** (include any limitations related to personal care, social interactions, manual tasks, etc.)

 - Academic experience** (note: please consider situations in and out of the classroom)

