Office of Disability Services
Dent Hall 106A
504.816.4370
DisabilityServices@dillard.edu

Office of Disability Services
Mental Health Documentation Form for Medical Providers

This form is to be completed by the Medical Provider and mailed to Dillard University Office of Disability Services, 2601 Gentilly Blvd., New Orleans, LA 70122. The information from this completed form will be used to determine a student's eligibility to receive disability accommodations.

Name of Student: ____ DOB _____/_____/______

Name of Medical Professional Completing this form ____

Title/Credentials/Lic # of Professional Completing this form ______________________________________

Address ____

City _______________________________ State ______________ Zip _____________________

Date of initial contact with the named student? Or, how long has this student been in your care? ______________

Date of the most recent evaluation? ____

How many sessions have you had with the student? ____

Name of Medical Professional Evaluator (if different) ____

Title/Credentials/Lic # of Professional Evaluator ____

What is the student's current diagnosis? Please include diagnostic codes from the DSM 5 or the ICD-10.

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Is this diagnosis mild, moderate, or severe? ____

What evaluation and method was used to make this diagnosis? _____________________________________

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Please describe any relevant history. Add additional pages if necessary. ______________________________

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What major life activity, as described in the ADA, does this diagnosis substantially limit? ____________________

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What are the relevant functional limitations in a college environment because of this diagnosis? ________________

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Please indicate the degree to which the diagnosis limits the student's major life activities? _____________________

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What is the treatment plan for this student? ____

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What, if any, medication, has been prescribed because of this diagnosis and the possible side effects?

medication ____

dosage/frequency ____

possible side effects ____

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medication ____

dosage/frequency ____

possible side effects ____

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medication ____

dosage/frequency ____

possible side effects ____

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Please list any suggested accommodations that are appropriate in a college environment that relate to this diagnosis, the major life functions that are limited, and how it is a disability that causes the student to be denied access to their education.

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Medical Provider Signature: ____

Date: ____

Practice Name: ____

Address: ____

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Phone Number: ____