LCSC Accessibility Services
500 8th Avenue
Library, Room 161
Lewiston, ID 83501

Phone: 208.792.2677
Fax: 208.792.2143
accessibilityservices@lcsc.edu
www.lcsc.edu/accessibility-services

Mental Health Verification Form

REQUEST FOR DISABILITY VERIFICATION OF A MENTAL HEALTH DISORDER

Anxiety Disorders, Major Depressive Disorder, Bipolar Disorder, Impulse-Control Disorder, etc.

Form is to be completed by the student's evaluator and then returned to Accessibility Services.

To ensure the provision of reasonable and appropriate services for students with a mental health disorder, the Accessibility Services office requires students to provide current and comprehensive documentation of their disability and its impact on their education. To standardize the gathering of such information, we ask that you complete the following and return to the address above. All material will be kept confidential.

Student Information

Student Name: _____

1. DSM-5 Diagnosis (ICD-10 Code) _____

2. Date of original diagnosis _____

   Please include any evidence of early impairment, whether or not the student received treatment:

3. Date of most recent evaluation _____
   (documentation should be current, within the last 3-5 years; include update of the diagnosis if diagnostic report is older than 6 months)

4. Summary of symptoms and test findings which support the diagnosis, including any results from testing. Please include: 1) history of presenting symptoms; 2) duration, severity and prognosis of the disorder; and 3) relevant developmental, historical and familial data. Describe below and attach a list of test instruments and results; subtests should be included:

5. Describe any treatment plan(s) including a description of the student's responsibility.

6. Describe the student's current functional limitations in an educational setting:

7. Is this student currently on medication(s) that may affect their academic achievement? If so, provide relevant information about their medical history:

8. Please provide your specific recommendations (based on your assessment, the student's clinical and academic history and diagnosis) for accommodations that you believe will help equalize the student's ability to access the Lewis-Clark State College's educational program.

LEWIS CLARK STATE COLLEGE
ACCESSIBILITY SERVICES

Evaluator Information

I certify, by my signature below, that I conducted or formally supervised and/or co-signed the diagnostic assessment of the student named above and that I am a licensed psychologist, neuro-psychologist, psychiatrist, or other relevantly trained medical doctor or counseling professional.

Print Name: _____
Title: _____
Area of Specialty: _____
State License(s): _____
License Number(s): _____
Address: _____
_____
Phone: _____ Fax: _____
e-mail: _____

Signature: _____ Date: _____

For Office Use Only

Accessibility Services Staff (Full Name): _____

Staff Signature: _____

Date Reviewed/Received: _____