

PSYCHOLOGICAL DISABILITY DIAGNOSTIC REPORT

To be completed by a certified medical professional.

In accordance with the Americans with Disabilities Act (ADA) of 1990 as amended, Section 504 of the Rehabilitation Act of 1973 (Section 504), Dongguk University Los Angeles (DULA) provides reasonable accommodations to students with disabilities. In order to do so, students should submit all accommodation requests to DULA Student Services Coordinator as the designated officer for disability services.

Students requesting accommodations should review the guidance provided by DULA Student Services Coordinator for documentation, but generally must submit documentation that clearly demonstrates that (1) the student has a physical or mental impairment, and (2) the impairment prevents the normal exercise of any bodily or mental functions (or can be shown to exist through accepted clinical or laboratory diagnostic tests), as compared to most people in the general population. A diagnosis of a disorder, or submission of an evaluation, does not automatically qualify an individual for accommodations. Appropriate documentation must be provided by a qualified professional, meet currency requirements, include diagnosis information as well as information about the functional limitations caused by the impairment, and support the request of specific accommodations. In some cases, DULA Student Services Coordinator evaluation may include review of documentation by an internal or external consultant engaged by DULA. Accommodations are determined through an interactive process that includes an intake interview.

This document requests information necessary to determine the impact of a medical disability on the student's ability to participate in the University's educational programs and to validate the need for accommodation(s). In instances where there are multiple diagnoses, including learning disabilities, ADHD or psychological disabilities, evaluators should consult DULA Student Services Coordinator for documentation requirements for those disabilities. A treating certified medical professional should complete this form or provide equivalent information on professional letterhead.

Designated University Officer for Disability Services:

DULA Student Services Coordinator
440 Shatto Place, 2nd Floor, Los Angeles, CA 90020
Phone: 213-487-0110 ext. 406, Email: AC@dula.edu

STUDENT INFORMATION

Full Name: _____ Legal Name (if different): _____

DULA Student ID: _____

Enrollment Status (choose that apply):

- Current MSOM Program Student ___ Active ___ On Leave of Absences
- Current DATM Program Student ___ Active ___ On Leave of Absences
- Current DAOM Program Student ___ Active ___ On Leave of Absences
- Non-matriculating Students ___ Active ___ On Leave of Absences
- Admitted into the program but undecided

DIAGNOSIS

DSM V Diagnosis	DSM V (or ICD-10) Code	Date of Diagnosis (MM/DD/YYYY)
		__ / __ / ____
		__ / __ / ____
		__ / __ / ____

In addition to DSM diagnostic criteria, how did you arrive at your diagnosis? (choose all that apply):

- Structured / unstructured interview with student
- Behavioral observations
- Consideration of development or medical history
- Interview with others (parents, teachers, etc)
- Rating scales (Beck Depression Scale, etc)
- Neuro/psycho educational testing

Other:

CURRENT TREATMENT

Is the student currently in treatment with you? ___ YES ___ NO

Initial Visit Date: ___ / ___ / ___ Date of Last Visit: ___ / ___ / ___

Name of additional treating professional if known: _____

If known, what if the visit frequency? _____

Current symptoms (indicate severity: Substantial (S), Moderate (M), Mild (MI),
Remission (R)):

Treatment history including current treatment:

Prognosis (Please give anticipated progression, duration, stability):

Current prescribed medications	Side effects impacting student

FUNCTIONAL IMPACT

Please indicate level of impact on ability to complete coursework or other academic program requirements, or impact on daily activities outside the classroom:

Functional Area	Substantial	Moderate	Mild	None	Don't know
Cognitive Processing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reasoning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attending Class	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meeting Deadlines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Following Directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organization and Time Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Interactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please provide detail on the functional impact, especially those ranked as substantial (please use additional paper for more information on the functional impact or additional comments).

Please provide recommendations for accommodations to support the student and include the rationale for those recommendations.

CERTIFYING PROFESSIONAL

Name: _____ Specialty: _____

Email address: _____ License (Type and Number): _____

Address: _____

Phone Number: _____ Fax Number: _____

I certify that the student named above has given me permission to release all information contained on this form for the purpose of considering eligibility for accommodations, modification or adjustments based on disability.

Signature: _____

Date (MM/DD/YYYY): ____ / ____ / ____