Verification of Psychiatric Disabilities

Thank you for assisting the student and the University in securing the documentation required to process the request for support services related to their psychiatric disorder.

The attached Verification of Psychiatric Disability form was specifically designed to allow you to efficiently provide the specific information required by the Centre for Students with Disabilities. Accurate completion of the form should assist you in ensuring that all the necessary information required to support the student has been provided. Should you wish to provide a written report, in place of the form, please be sure that the report addresses all issues captured in the form.

While a psychiatric disorder may be a source of discomfort or distress, most of the more common psychiatric disorders, such as generalized anxiety disorder and major depressive disorder, do not necessarily rise to the level of causing disability. In order to trigger consideration of accommodation, the documentation required must clearly describe how such an impact is created as to substantially limit major life activities or necessitate reasonable accommodation. Please note that “test anxiety,” although common in this population, is normally not seen as a disability unless it is a functional limitation of a more encompassing DSM-5 psychiatric disorder.

All documentation provided must be authoritative, comprehensive and current.

Authoritative: To be authoritative, the documentation for most psychiatric disabilities must be provided by a psychiatrist or registered psychologist. For certain conditions, such as an Autism Spectrum Disorder, authoritative documentation may also be provided by a neurologist. In all cases, the diagnosing professional must have established expertise in the differential diagnosis of the psychiatric disorder in adolescents and adults. Comprehensive documentation meeting all other requirements, but which is from a family physician, may be adequate to support the provision of temporary or interim accommodations. The purpose of this interim period of support is to allow time for a student to seek the required documentation from a qualified assessor (psychiatrist or registered psychologist).
**Comprehensive**: To be comprehensive, the documentation needs to verify that a DSM-5 diagnosis has been established *(note that reporting the specific DSM diagnosis is optional)*. The documentation needs to describe the ways in which the impairment substantially limits a major life activity or necessitates reasonable accommodation. In addition, there should be information about current treatment including a description of the impact of medications on the level of impairment experienced by the student, or conversely the level of impairment associated with use of the medication. There should be a statement about the expected prognosis of the disability and whether the condition is permanent or temporary. As well, the assessor should indicate if, and when, periodic reassessment is needed.

Please note that a brief letter stating that a student has a particular psychiatric disability, takes medication to treat the condition, and needs reasonable accommodations is very unlikely to meet the university's documentation requirements.

**Current**: To be current, the documentation must describe the symptoms and levels of impairment presently experienced by the student. This is particularly critical due to the possible changing nature of most psychiatric conditions, and as the determination of accommodations is based on an understanding of the current impact of the disorder.

Should you have questions regarding this form or the requirements, please do not hesitate to contact the Centre.

Centre for Students with Disabilities
Simon Fraser University
VERIFICATION OF PSYCHIATRIC DISABILITY
(Not for use with AD/HD or LD)

Student Name: ______________________________ Student Number: __________________

Student’s Date of Birth: ________________________

STUDENT’S INFORMED RELEASE

The information on this form is collected under the general authority of the University Act (R.S. B.C. 1996, c. 468, s.27(4)(a)) and Simon Fraser University Policy GP-26, Accessibility Policy for Students with Disabilities. The information will be used only for services directly related to your studies at Simon Fraser University. If you have any questions about the collection and use of this information please contact the Director, SFU Centre for Students with Disabilities, 778-782-3313.

In addition to the personal information collected on this form we may need to collect additional personal information about you from your health care practitioner (e.g., doctors, psychologists). These persons or organizations are authorized to disclose such information. The personal information collected from these persons or organizations relates specifically to the disability and services or equipment required because of the disability. This information is collected and used for the same purposes as noted above.

By signing below I agree to the terms and conditions of CSD registration and authorize the CSD to collect, use and share personal information about me as noted above. I understand that failure to agree and give my authorization will result in an inability for the CSD to adequately provide services or academic accommodations required because of my disability.

I, ______________________________ authorize the professional named at the bottom of this form to release this Verification of Psychiatric Disability Form to the Centre for Students with Disabilities at Simon Fraser University.

_________________________________________ ______________________________
Signature of Student       Date
VERIFICATION

- To be completed by a **Psychiatrist or Registered Psychologist**. The qualified diagnosing professional must have expertise in the differential diagnosis of the documented mental disorder or condition in adolescents and adults, and must follow established practices in the field.

- A separate report, which includes all the necessary information outlined below, may also be acceptable in place of this verification form.

- At the discretion of the CSD, comprehensive documentation from the family physician may be accepted for the purpose of establishing *temporary or interim* accommodations.

- Refer to the CSD’s online documentation guidelines for diagnoses of ADHD and/or LD, as a comprehensive report is required to document these conditions.

1. **Confirmation of DSM Diagnosis:**

   A. **REQUIRED** - I have diagnosed the student with a psychiatric condition recognized within the DSM *(DSM-5 for assessments completed after May 2013; DSM-IV for assessments completed before May 2013)*

   B. **OPTIONAL** – The student’s diagnosis/diagnoses can be included in the table below. While students are not required to provide formal diagnosis of their psychiatric condition to receive services, having this information, along with information from the student, enables the CSD to provide the best possible service.

<table>
<thead>
<tr>
<th>Dx Code</th>
<th>Dx Name</th>
<th>Specifiers</th>
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<tbody>
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2. Date the student was first seen by you: ____________________

3. Date the diagnosis was first established by you: ____________________

4. Date the student was most recently seen by you for this condition: ____________________

5. Prognosis - the disability is:

   - [ ] Permanent (ongoing symptoms expected for the duration of natural life)
   - [ ] Temporary (condition not expected to persist for greater than one year)

   Estimated recovery date: ____________________
6. A. The nature of this condition is (please check all that apply):
   □ Stable
   □ Chronic
   □ Fluctuating
   □ Episodic
   □ Degenerative
   □ Other: ____________________________________

   B. If applicable, at what frequency should the impact of the condition be reassessed?

7. What are the major symptoms of the disorder, and associated levels of severity, currently manifested by the student, that contribute to the diagnosis and are expected to result in impairments in the student’s ability to participate in post-secondary studies?

<table>
<thead>
<tr>
<th>Symptom/Impairment</th>
<th>Severity</th>
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8. A. Is the student currently taking medication(s) for their symptoms? □ YES / □ NO

   B. If yes, please describe the residual impairments or any impairments arising as side effects of the medication which impact on the student’s ability to complete academic activities:

   ____________________________________
   ____________________________________

9. Is the student involved in any other (e.g., non-pharmacological) treatment for their symptoms which might interfere with participation in academic studies? If yes, please describe.
10. What is the expected functional impact of the condition on the student's ability to effectively engage in academic studies? Please indicate the level of limitation while on medication, if applicable.

<table>
<thead>
<tr>
<th>Academic Activity</th>
<th>Don’t Know</th>
<th>No Impact</th>
<th>Mild Impact</th>
<th>Moderate Impact</th>
<th>Severe Impact</th>
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<tbody>
<tr>
<td>Concentrating</td>
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<tr>
<td>Managing external distractions</td>
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<tr>
<td>Managing internal distractions</td>
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<td>Managing time</td>
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<tr>
<td>Planning, Strategizing, Organizing</td>
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<td>Regular and timely attendance</td>
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<td>Remembering</td>
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<td>Thinking and reasoning</td>
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<td>Eating</td>
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<td>Self-care</td>
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<td>Sleeping</td>
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<td>Social interactions</td>
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<td>Limited functioning at certain times of day (please specify): __________</td>
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<td>Other:</td>
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11. In your best estimation, based on an appreciation of your above ratings, do you believe that the student is capable of effectively meeting the essential demands of post-secondary studies at this time?

YES: ☐ Full-time (3 or more courses) ☐ Part-time (1 or 2 courses)

NO: ☐ Not at this time

12. Is there anything else you think we should know about the student's psychiatric disability?

CERTIFICATE OF PROFESSIONAL  ☐ Psychiatrist  ☐ Registered Psychologist

Signature of Professional ________________________________ Date ________________

Professional’s Name (printed) ________________________________ License Number ________________________________

Address _________________________________________________

Telephone No. ________________________________ Fax No. ________________________________