MORAVIAN
UNIVERSITY

Psychological Condition Documentation

The Accessibility Services Center (also referred to as the ASC) complies with federal and state disability laws that prohibit discrimination and equal access for qualified persons with disabilities to educational programs, services, and activities. Medical providers must complete this form to assist the ASC in determining eligibility, appropriate and reasonable disability accommodations. ***The medical provider cannot be a family member, friend, or relative of the student. Please print legibly.***

Student's First and Last Name: _____

Condition Information:

List the DSM-Diagnosis/ICD-10 Code(s):

Date of initial contact with the student: _____

When was the condition first diagnosed? _____

How long have you been treating the student? _____

What is the frequency of appointments? _____

Date of the last visit for the condition: _____

Did the student receive emergency room treatment for this condition within the last year? ☐ Yes ☐ No

Date(s) treated: _____

Has the student received in-patient treatment for this condition within the last year? ☐ Yes ☐ No

Date(s) treated: _____

Medication Information:

Is the student currently taking medication? ☐ Yes ☐ No ☐ Does not apply.

If yes, please provide information on each medication below:

Medication 1:
Name of Medication: _____
Date Prescribed: _____
Side effects: _____

Medication 2: ☐ Not applicable.
Name of Medication: _____
Date Prescribed: _____
Side effects: _____

Medication 3: ☐ Not applicable.
Name of Medication: _____
Date Prescribed: _____
Side effects: _____

Medication 4: ☐ Not applicable.
Name of Medication: _____
Date Prescribed: _____
Side effects: _____

Diagnosis Procedures/Assessment:

In addition to the DSM criteria, how did you arrive at your diagnosis? ***Please attach copies of the assessment results if applicable.*** Select all that apply to this student:

☐ Behavioral observations
☐ Developmental history
☐ Educational history
☐ Interviews with other individuals
☐ Medical history
☐ Neuropsychological testing. Testing date: _____
☐ Psychoeducational testing. Testing date: _____
☐ Standardized or unstandardized rating scales
☐ Structured or unstructured interviews with the student
☐ Other. Please explain:

Current Symptoms:

List the student's current symptoms:

How do the symptoms affect the student's academic engagement?

Functional Limitations:

The table below indicates the impact of the condition on the student's academic and daily activities. For each line, check the box or place an "X" under the heading if the academic and daily activities have "No Impact," "Moderate Impact," "Substantial Impact," or is Unknown, respectively.

Academic and Daily Activities	No Impact	Moderate Impact	Substantial Impact	Unknown
Attending class regularly and on time				
Complex/Abstract Thinking				
Concentration				
Eating				
Making and keeping appointments				
Managing internal distractions				
Memory				
Organization and prioritization of tasks				
Self-care				
Sleeping and waking				
Social interaction				
Stress management				
Other. Please describe below.				

Describe how the above condition substantially limits a significant life activity that the average person in the general population can perform with little or no difficulty.

How does the student's condition impact their daily life experience in the post-secondary setting, such as in academics, communal living/dining, recreation, etc.?

What are the recommendations for health care and symptom management for the above conditions while on campus?

If the student is on medication, how does it impact the functional limitations listed above?

What symptoms will accommodations target or mitigate?

What specific accommodations would help the student?

Is there any additional information we should know about the student's psychological condition?

Please use additional pages should you need more space to explain the requested information.

Medical Provider Information:

What is the role of the medical provider? _____

Provider's Full Name: _____ Practice Name: _____

Provider's Street Address: _____

City: _____ State: _____ ZIP Code: _____

License or Certification: _____ State: _____ Specialty: _____

Phone Number: _____ Fax Number: _____ Email: _____

Provider's Signature: _____ Date completed: _____

Please attach a copy of the medical provider's business card or stamp to this form.

Student's Section and Release:

The ASC encourages students to sign this form and submit it along with the documentation completed by their medical provider. Signing and submitting this release will expedite the communication between the ASC and the medical provider, avoiding delays in the accommodation process.

I, _____ (print the student's first and last name), certify the following:

- My medical provider completed this form.
- I authorize my medical provider to release the medical information requested on this form to the ASC so that they can determine appropriate accommodation(s) for my condition(s).
- I give the ASC permission to communicate with my medical provider and to discuss the information contained in this form.
- I understand that if I do not have my medical provider complete this form and consult with the ASC, it may result in significant delays in processing accommodations.

Student Signature: _____ Date Form Completed: _____

Form Submission:

Do not submit medical documentation via email but use one of the secure methods listed below.

- The documentation can be faxed securely to (610) 625-7877.
- Upload the PDF securely by visiting http://bit.ly/ascdocumentation.
- The student may upload the completed PDF by doing the following:
  - Log in to ***Accommodate*** (https://moravian-accommodate.symplicity.com)
  - Click on ***Documents***
  - Click on ***Approved Documents***
  - Click on ***Add New***
  - Complete the form.