Gettysburg College
Documentation for ADD/ADHD/Psychiatric/Neurological Disorders
Provider form

I. Student – To be Completed by the Student
Name: Last______________________________
First___________________________MI____
Date of Birth_____________________ Phone____________________________________
Address_______________________________________________________________________
______________________________________________________________________________

II. Certifying Professional – To be Completed by the Healthcare Professional - *please note guidelines below for appropriate provider.
Name____________________________________________________________________________
Area of Specialty________________________________________
License/certification number, and state: _________________________________
Phone_______________________________________Email________________________________
Address________________________________________________
______________________________________________________________________________

Documentation Guidelines for Psychiatric/Neurological Disorders: Assessment must be completed by a licensed psychologist, neurologist, neuropsychologist, psychiatrist, or physician known to specialize in psychiatric disorders. Because psychiatric/neurological disorders can change over time, documentation must be up to date. The evaluation should have been completed or updated within the past year. The initial evaluation in which the psychiatric or neurological disorder was diagnosed should be included. The current psychiatric/neurological update can be the completion of the Documentation for Psychiatric/Neurological Disorder Form or a comprehensive report that outlines all the components of the form.

Please note: A one-page memo/letter or a script that merely outlines the diagnosis(es) and recommendations for accommodations is not acceptable. If the student has a learning disability or suspected learning disability, the student should be referred for a psychological or neuropsychological evaluation, if one has not been completed within the past three years.

III. Diagnosis

1. What were the dates you met with this student?

2. Please attach information to substantiate the diagnosis/diagnoses. Appropriate information could include, for example, thorough psychiatric or neurological evaluation. If standardized assessment was completed, please attach all scores/results and a brief discussion of each.
3. Please list DSM-5 or ICD-10 diagnostic codes, date(s) diagnosed, and indicate which constitutes the disabling condition.

IV. Statement of Disability

1. In your opinion, does any condition listed above substantially limit a major life activity and thereby rise to the level of *disability? Yes_____ No_____ Not sure_____ (If yes, indicate which one(s) above with an asterisk.)

* A disability is defined under the Americans with Disabilities Act as “A physical or mental impairment that substantially limits one or more major life activities.”

2. When was this student first determined to have a disabling condition?

3. What accommodations for this condition has the student received in the past?

V. Functional Limitations that may warrant accommodations. Please describe degree of limitation for the condition(s)—mild, moderate, severe—and provide an example of how this limits a major life activity.
VI. Recommended accommodations  For each recommendation, please indicate if this is ESSENTIAL or PREFERRED. “Essential” indicates that the student cannot participate equally in the educational experience unless this accommodation is in place—nothing else will do. “Preferred” indicates that an accommodation is desirable but not essential for equal participation. A specific diagnosis does not guarantee a specific accommodation – please describe this student’s unique needs.

*If housing accommodations are being recommended – please clearly identify the need for the accommodations. Be aware that a specific diagnosis does not guarantee a specific accommodation – please describe this student’s unique needs. For dietary restrictions – the student must FIRST meet with Dining Services to identify their ability to meet the required needs. Only after this meeting has occurred will our office consider alternate housing options – such as residential kitchen access.

VII. Supplemental Information

1. Is the student taking medication for this condition?

2. What symptoms remain despite medication treatment?

3. What is the student’s level of compliance with the treatment regime?

4. Will the student require therapy at college?

5. Prognosis: the likelihood of the student’s ability to function effectively in a college environment:

   With recommended treatment regime: Poor _____ Fair _____ Good _____ Excellent ______

   Without recommended treatment regime: Poor _____ Fair _____ Good _____ Excellent ______
Other Comments/Recommendations:

________________________________________________________

________________________________________________________

SIGNATURE                     DATE

Please return this form to:

Gettysburg College
Office of Academic Advising
300 North Washington St
Campus Box 414
Gettysburg, PA 17325
717-337-6579/Fax 717-337-6245

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