



Office for Disability Services
Southern Maine Community College
2 Fort Road
South Portland, ME 04106

Phone: (207) 741-5832 or
(207) 741-5923
Fax: (207) 741-5678

Services for Students with Diagnosed Disability

Psychiatric Disability - PROVIDER FORM

The information you provide will not become part of the student's educational records. It will be kept in the student's file at **ODS**, where it will be held strictly confidential.

Student Name: _____ **DOB:** _____

1. DSM—V Diagnosis: _____

Date of diagnosis: _____

Last date of contact with client: _____

2. Please rate severity of the disability on a scale of 1(mild) to 10 (severe) _____

3. Is the condition considered chronic? ____Yes ____No

If NO, expected recovery time: _____

4. Does the disability cause a threat to safety of self or others? ____ Yes ____ No

Please explain:

5. Please discuss any history of hospitalization and any planned therapeutic interventions:

6. Provide information regarding the student's current presenting concerns and symptoms:

7. Please check which of the following areas are affected significantly enough to have a negative impact in a college academic or on-campus residential setting:

Check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Oral Expression | <input type="checkbox"/> Time management/organization |
| <input type="checkbox"/> Written Expression | <input type="checkbox"/> Concentration |
| <input type="checkbox"/> Written Reception | <input type="checkbox"/> Managing Internal Distractions |
| <input type="checkbox"/> Auditory Reception | <input type="checkbox"/> Managing External Distraction |
| <input type="checkbox"/> Perceptual Distortions | <input type="checkbox"/> Stress management |
| <input type="checkbox"/> Delusions | <input type="checkbox"/> Timely submission of work |
| <input type="checkbox"/> Memory | <input type="checkbox"/> Regular class attendance |
| <input type="checkbox"/> Self-Care | <input type="checkbox"/> Making and keeping appointments |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Working in groups |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Social interactions |

Please provide further details related to any item checked:

8. Is the condition variable over time? ____Yes ____No

Please explain:

9. Is the student under pharmacological treatment? Any side effects that might impact their education?

10. Determination of reasonable accommodations in the academic setting will be decided by the SMCC Disability Support Services professional after review of disability documentation. Suggestions and/or recommendations are welcome along with an explanation of the relevance related to the diagnosis.

Please attach your Psychological Report or testing utilized and any other relevant data.

Professional information:

Name: _____

Title: _____

Credentials: _____

Contact information: _____

Signature of diagnosing professional: _____

Date: _____

PLEASE RETURN THIS FORM TO:

Southern Maine Community College

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Email: disabilityservices@smccme.edu

www.smccME.edu