ST MARY'S
COLLEGE *of* MARYLAND
The National Public Honors College

OFFICE OF ACCESSIBILITY SERVICES
47645 College Drive
St. Mary's City, MD 20686

www.smcm.edu
TEL: 240-895-2250
FAX: 240-895-2234

Documentation Form for Mental Health Disabilities

This information submitted to Accessibility Services should reflect the most currently available information. **This Mental Health Disability Documentation Form should:**

a) Be completed by a qualified professional.

b) ***Be completed as clearly and thoroughly as possible.*** Incomplete responses and illegible handwriting may require additional follow up.

c) ***Be supplemented with reports which may include psycho-educational or neuropsychological reports, if applicable***. Please do not provide case notes or rating scales without a narrative that explains the results.

Submit Information to:

Office of Accessibility Services

Glendening Hall 253 & 254
St. Mary's College of Maryland
47645 College Drive
St. Mary's City, MD 20686

FAX: 240-895-2234
PHONE: 240-895-2250
EMAIL: adasupport@smcm.edu

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SMCM Student Name: SMCM Student ID:

Date form is being completed:

1. Clinician's date of first contact with this student:

2. Clinician's date of last contact with this student:

3. Are you:

The diagnosing clinician, but you are no longer treating the individual
The diagnosing clinician who is still treating the individual
The clinician currently treating the condition, but you are using a diagnosis provided by another clinician

4. Please state the complete diagnosis/diagnoses:

5. How was the diagnosis established? Please check all relevant items below:

Structured or Unstructured interview
Interviews with other person
Behavioral Observations
Other (Please specify):

Medical tests
Medical History
Developmental History

6. Describe the limitations that are created as a result of this diagnosis, with specific attention to ways those limitations influence classroom and learning behaviors.

7. Describe the **strategies and supports that have previously worked** to address academic limitations. Provide rationales.

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8. Describe any limitations that could impact housing/dining.

9. Describe the **strategies and supports that have previously worked** to address living Limitations. Provide rationales.

10. Discuss any ***side effects related to treatment or medication*** that may be relevant to identifying accommodations.

11. Provide any ***additional information you feel is pertinent*** or may be of use in identifying appropriate accommodations.

Provider Information

Provider Name (Print):

Provider Signature:

License or Certification #:

Address:

Phone: FAX: