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Documentation of Psychiatric Disorders / ADD/ ADHD Verification Form

As the diagnosing professional, please fully complete all sections of this form. Additional reports, information, or narrative can be attached if appropriate.

Please note: All information that you provide may be shared with this student unless clearly marked otherwise. Thank you for your assistance.

I, _____, hereby authorize the release of the following information to disAbilityAccess Services at Guilford Technical Community College for the purpose of determining my eligibility for services.

_____ _____ _____
 Student Signature Date of Birth Date of Request

TO BE COMPLETED BY THE DIAGNOSING PROFESSIONAL

I. Diagnosis

IEP's are acceptable as supporting documentation to a diagnosis, but are not acceptable for a diagnosis alone.

Psychological Evaluations and / or Psycho-Educational Evaluation

Other supporting Evaluative reports

Primary Diagnosis _____

ICD-9, ICD-10 or DSM Code: _____

Date of Diagnosis: _____ Date of Last Evaluation: _____

What is the expected duration? _____

Secondary Diagnosis _____

ICD-9, ICD-10 or DSM Code: _____

Date of Diagnosis: _____ Date of Last Evaluation: _____

What is the expected duration? _____

Other Diagnosis _____

Date of Diagnosis: _____ Date of Last Evaluation: _____

What is the expected duration? _____

II. Treatment

Date of Last Visit: _____

How often do you provide treatment?

Prescribed Medication	Side Effects

III. How does the disability impact the student within the educational setting? (e.g. Difficulty focusing within a classroom, taking notes while listening to instruction or regulating emotions during a stressful situation, etc. These limitations may result in a student possibly needing such services as testing in a less distracting environment, extended time on an exam, or alternative ways in getting notes.)

Recommended Accommodations:

Thank you for your cooperation in this matter. Your prompt attention will allow us to begin providing services as soon as possible. Incomplete or missing information can prevent or delay necessary services. This form must be completed and signed by the qualified professional who performed the evaluation and made the diagnosis.

Professional Credential Documentation (PLEASE ATTACH YOUR BUSINESS CARD TO THE DOCUMENT OR ANOTHER FORM OF IDENTIFICATION FOR THE STUDENT FILE.)

Name _____

Address _____

Title _____

Professional Credentials _____ Phone : _____

License/Certification number _____

Signature _____ Date _____

To expedite the process, you may fax a copy to **1-336-232-9803**. All documentation is confidential. In addition to Faxing, please mail the signed, original form to:

Guilford Technical Community College:
 disAbility Access Services
 P.O. Box 309
 Jamestown, NC 27282
 Attention: _____