PART I
TO BE COMPLETED BY EVALUATOR

DISABILITY SERVICES – LOUISIANA STATE UNIVERSITY

PSYCHOLOGICAL DISABILITY DOCUMENTATION REQUEST FORM

**** This form must contain ALL of the requested information and be TYPED or PRINTED in order to apply for accommodations through Disability Services. ****

Student’s Name: _______________________________________________________________________________
Date of Birth: ______________________
Address: _____________________________________________________________________________________
Phone Number: _______________________________________________________________________________
LSU ID Number: ______________________ LSU Email: ______________________________________

This student is requesting an auxiliary aid or service, academic adjustment, and/or other accommodations from Disability Services. In order to consider this request, as well as to ensure the provision of reasonable and appropriate auxiliary aids and services, University Policy requires that a Qualified Professional provide current and comprehensive documentation. A qualified professional is a licensed mental health professional who is not a family member of the student. IN ORDER TO BE CONSIDERED CURRENT, THE QUALIFIED PROFESSIONAL’S STATEMENT MUST BE WITHIN 6 MONTHS PRIOR TO THE DATE OF THE MOST RECENT REQUEST FROM DISABILITY SERVICES.

The documentation provided must include information that indicates a diagnosis of a psychological disability (as diagnosed by the DSM-5), describes the functional limitations in an educational setting, indicates the severity and longevity of the psychological disability for the purpose of determining academic adjustment(s) or other accommodation(s), and lists current medication and any current side-effects which may impact academic performance.

To facilitate the gathering of such critical information, please respond to the following and return to Louisiana State University’s Disability Services.

1. Diagnosis (as diagnosed by the DSM-5): _________________________________________________________

2. Date of Diagnosis: ______________________  Date of Last Contact with Student: ______________________

3. Provide a summary of the student’s educational, medical, and family history that relates to the psychological disability (difficulties must be related to the diagnosed disability and are not the result of other conditions, cultural differences, or insufficient instruction): ______________________________________________________
   _______________________________________________________________________________________
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   __________________________________________________________
4. Describe the student’s functional limitations (i.e., current and/or anticipated problems associated with the condition) in an educational setting: __________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

1. List current medication along with any current side effects that may impact academic performance: ______
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

2. Please indicate the RECOMMENDATIONS you have regarding necessary and appropriate auxiliary aids or services, academic adjustments, or other accommodations to equalize the student’s educational opportunities at LSU as justified based on the functional limitations indicated above.

   Please check all that apply:  ___ Extended Time (1.5X)  ___ Distraction Reduced Environment
   ___ Note-Taking  ___ Consideration for Absences  ___ No Scantron
   ___ Reader  ___ Scribe  ___ Other ________________________________

Qualified Professional’s Signature: ________________________________

Printed Name & Title: _____________________________________________

Daytime Telephone Number: _______________________________________

Address: ________________________________________________________

Date: _____________________________________________________________________

Disability Services
Louisiana State University
115 Johnston Hall
Baton Rouge, LA 70803
Phone: 225-578-5919
Fax: 225-578-4560
PART II
TO BE COMPLETED BY STUDENT

DISABILITY SERVICES – LOUISIANA STATE UNIVERSITY

REQUEST FOR ACCOMMODATIONS

Student’s Name: __________________________________________________________
Date of Birth: __________________________________________________________
Address: ______________________________________________________________
Phone Number: __________________________________________________________
LSU ID Number: ___________________________ LSU Email: ________________________

I am requesting accommodations because I have been diagnosed with one or more of the following disabilities which functionally impairs my ability to perform in an academic environment: (Check all that apply)

☐ Attention Deficit/Hyperactivity Disorder    ☐ Learning Disability
☐ Psychological Disability                    ☐ Deaf & Hard of Hearing
☐ Physical or Systemic (Medical) Disability (specify): ________________________________

In the space below and (if needed) on the back of this sheet, please list and explain the reason behind each of the accommodations you are requesting. Please be as specific as possible.

____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Signature of Student: ___________________________ Date: ______________________________

Please note: Disability Services strongly recommends maintaining copies of any submitted documentation for your own, personal records.