SUNY BROOME | ACCESSIBILITY RESOURCES OFFICE

ARO is located on the ground floor of the Library, L017. For appointments and information, call 607-778-5150, VP 607-238-2714 or email aro@sunybroome.edu

Mental Health Provider Form

A licensed provider (e.g., psychologist, psychiatrist, neuropsychologist, social worker, psychotherapist) may use this form to provide information related to the student's psychological disability. This information will be used in conjunction with a student interview to begin assessing the functional impact of the student's disability and appropriate equal access academic accommodations. Please comment on all sections. If available, you may attach your most recent clinical note and an initial evaluation to clarify responses.

Forms may be completed electronically, but must include either an **original signature** or **office stamp** to be authenticated. **FORMS WITHOUT THESE WILL NOT BE REVIEWED.**

Student's Legal Name: _____

Student's Preferred Name and Pronouns: _____

Student's Date of Birth: _____

Provider/Student Relationship

1. How long have you been working with the student? _____

2. When did you last see the student? _____

Diagnostic Information

3. Please list any known DSM-5 diagnoses and original date of each. Please include those self-reported, diagnosed and ones based on history:

_____

_____

4. Please identify the diagnosis for which you are providing treatment or services:

_____

5. Please indicate how the treating diagnosis was determined; (e.g., comprehensive psychological evaluation, checklist, self-report, from an in-patient or outpatient hospitalization or derived in any other means).

_____

_____

6. Does the student have any other diagnoses not pertaining to mental health (e.g. medical, learning disability, ADHD)? □YES □NO □ UNKNOWN If Yes, please list below:

_____

_____

History and Functional Impact

7. What is the student's presentation at baseline:

a. Appearance/speech: _____

b. Mood and Affect: _____

c. Thought process: _____

8. Has the student had any inpatient hospitalizations, emergency mental health visits?

□YES □NO □UNSURE

Date of the most recent hospitalization: _____

9. Please describe the functional impact experienced by the student in relation to their mental health diagnoses as it pertains to an **academic setting** (e.g., impact on studying, test taking, note-taking).

_____

_____

_____

_____

10. Please describe the functional impact experienced by the student in relation to their mental health diagnoses as it pertains to **daily living** (e.g. eating, sleeping, transportation, recreation).

_____

_____

_____

_____

11. Please describe all current treatments and management strategies (e.g., stress-reduction, resources, coping strategies, on-going therapeutic services).

_____

_____

_____

_____

12. Is the student currently prescribed medication? □YES □NO

If yes, does the prescribed medications have any side effects that functionally impact their academics or daily living.

_____

_____

_____

_____

13. Is the student's disability cyclical or episodic in nature? □YES □NO

If yes, please provide details regarding the functional impact on their academics or daily living.

_____

_____

_____

Provider's Contact Information:

Name and credentials: _____

Area of specialization (e.g., psychiatrist, nurse practitioner, psychologist): _____

Address: _____

Fax and/or email address: _____

Telephone Number: _____

Professional Signature: _____

License Number and State: _____

Date: _____