



**Disability Services**  
[disabilityservices@byuh.edu](mailto:disabilityservices@byuh.edu)  
 808-675-3518

### VERIFICATION FORM for PSYCHOLOGICAL DISORDERS

BYU–Hawaii supports a climate of equal opportunity in its programs, activities, and services according to applicable law, including providing accommodations for students with disabilities. As part of the process for requesting accommodations, a student must provide documentation from a qualified practitioner who is the primary treating professional (e.g., psychiatrist, clinical psychologist, clinical social worker, licensed counselor) regarding a student’s mental health symptoms, related medications, and their impact on the student’s major life activity, and their need for accommodations. This Verification Form may supplement information that is provided in other reports, including neurological reports, neuropsychological evaluations, or secondary school documentation. Any documentation, including this Verification Form, must meet BYUH DS guidelines for psychological disorders.

A summary of the guideline criteria for documenting psychological disorders is listed below (more information related to DS documentation and guidelines for psychological disorders can be found at the following website: <https://disability.byuh.edu/>)

1. Evidence of current psychological disorder
2. Exclusion of alternative diagnoses
3. Functional limitations affecting an important life skill, including academic functioning
4. History relevant to current psychological disorder
5. Summary and recommendations

This form will be reviewed by the Disability Services Coordinator (DSC) who will verify the disability as to the reliability of the request. The DSC will then notify the student if they are eligible for accommodations.

### I. Student Information Section: (Please Print Legibly or Type)

**BYUH ID #:**

Student’s Name

First:

Middle:

Sur/Last:

Date of Birth:

Student’s Current Address:

Street:

City:  State:  Zip:

Phone:

Email:

**II. Provider Section:**

**1. Contact with Student**

- a. Date of initial contact with student:
- b. Date of last contact with student:
- c. Frequency of appointments with student (e.g., once a week, once a month):

**2. Diagnosis**

**a. DSM-5 Codes:**

i. Please include all pertinent diagnoses or rule-out diagnoses using *DSM-5* codes. Please be specific with regard to the diagnosed disorder (i.e., specific anxiety disorder, depressive disorder, etc.)

Principal Diagnosis: \_\_\_\_\_

Code: \_\_\_\_\_

Severity or Level of Impairment: \_\_\_\_\_

Descriptive Features: \_\_\_\_\_

Course: \_\_\_\_\_

Other Diagnoses: \_\_\_\_\_

Code: \_\_\_\_\_

Severity or Level of Impairment: \_\_\_\_\_

Descriptive Features: \_\_\_\_\_

Course: \_\_\_\_\_

WHODAS 2 Score (If given): \_\_\_\_\_

b. When was the student diagnosed? Month  Year

**c. Current Symptoms:**

i. Please provide information regarding the student's current presenting symptoms.

- ii. Is there clear evidence that the student's symptoms associated with the psychological disorder are interfering with or reducing the quality of at least one of the following, including academic functioning? Describe how the disorder interferes with functioning.

School functioning:	
Social functioning:	
Work functioning:	

### 3. Student's History

- a. Please include any historical information relevant to the student's psychological disorder and associated functioning (e.g., developmental, familial, medical, pharmacological, psychological, psychosocial).

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### 4. Psychological Treatment

- a. Medications:

- i. Is the student currently taking medication(s) for psychological disorder symptoms?

Yes  No

- ii. If yes, please provide information below for each medication the student is currently prescribed:

<b>Medication/Dosage/Frequency:</b>	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

<b>Medication/Dosage/Frequency:</b>	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

<b>Medication/Dosage/Frequency:</b>	
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<b>Medication/Dosage/Frequency:</b>	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

b. Therapies:

i. Is the student currently participating in psychological therapy (e.g., psychotherapy, group therapy, cognitive-behavior therapy)? If so, what is the nature of the therapy, how long has the student been in therapy, and how often does the student participate?

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**5. Functional Limitations and Recommended Accommodations**

- a. Please list the student's current symptoms associated with the psychological disorder and indicate what reasonable academic accommodations would mitigate the symptom listed. More detailed information regarding reasonable academic accommodations can be found on the DS website at: <https://disability.byuh.edu/>

<b>Symptom:</b>
<b>Recommended Reasonable Accommodation(s):</b>

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<b>Recommended Reasonable Accommodation(s):</b>

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<b>Recommended Reasonable Accommodation(s):</b>

\*Use the back, if necessary.

### III. Provider's Certifying Professional Information:

**Professionals conducting the assessment, rendering a diagnosis, and providing recommendations for reasonable accommodations must be qualified to do so (e.g., licensed physician, psychiatrist, clinical psychologist, or neuropsychologist). The provider signing this form must be the same person answering the above questions.**

**\*Note:** For ethical reasons, documentation from a family member or relative cannot be accepted, even if they are licensed.

Provider's Name: (International Providers, please fill out as much information as possible about your qualifications)

First:

Middle:

Last:

Credentials:

License Number\*:

State of Licensure:

Street Address:

City:

State:

Zip:

Phone #:

Email Address:

Signature of Provider:

Date:

Stamp Here (unless provider is from BYUH):

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***I authorize BYU–Hawaii to receive information from the healthcare provider above. I also authorize my healthcare provider to discuss relevant information as to my condition(s) with the appropriate and qualified BYU–Hawaii personnel on an as-needed basis.***

Signature of Student:

Date:

#### Submitting this Form:

This form may be returned to the student or submitted directly to the Disability Services Office at BYU–Hawaii. Information regarding BYU–Hawaii's Disability Services Office can be found at: <https://disability.byuh.edu/>. If you have any additional questions, you may contact [disabilityservices@byuh.edu](mailto:disabilityservices@byuh.edu) or 808-675-3518. Thank you for assisting BYU–Hawaii in this accommodation process.