University of Nevada, Las Vegas
Disability Resource Center
4505 S. Maryland Parkway
Box 452015
Las Vegas, NV 89154-2015

Phone 702-895-0866
FAX 702-895-0651

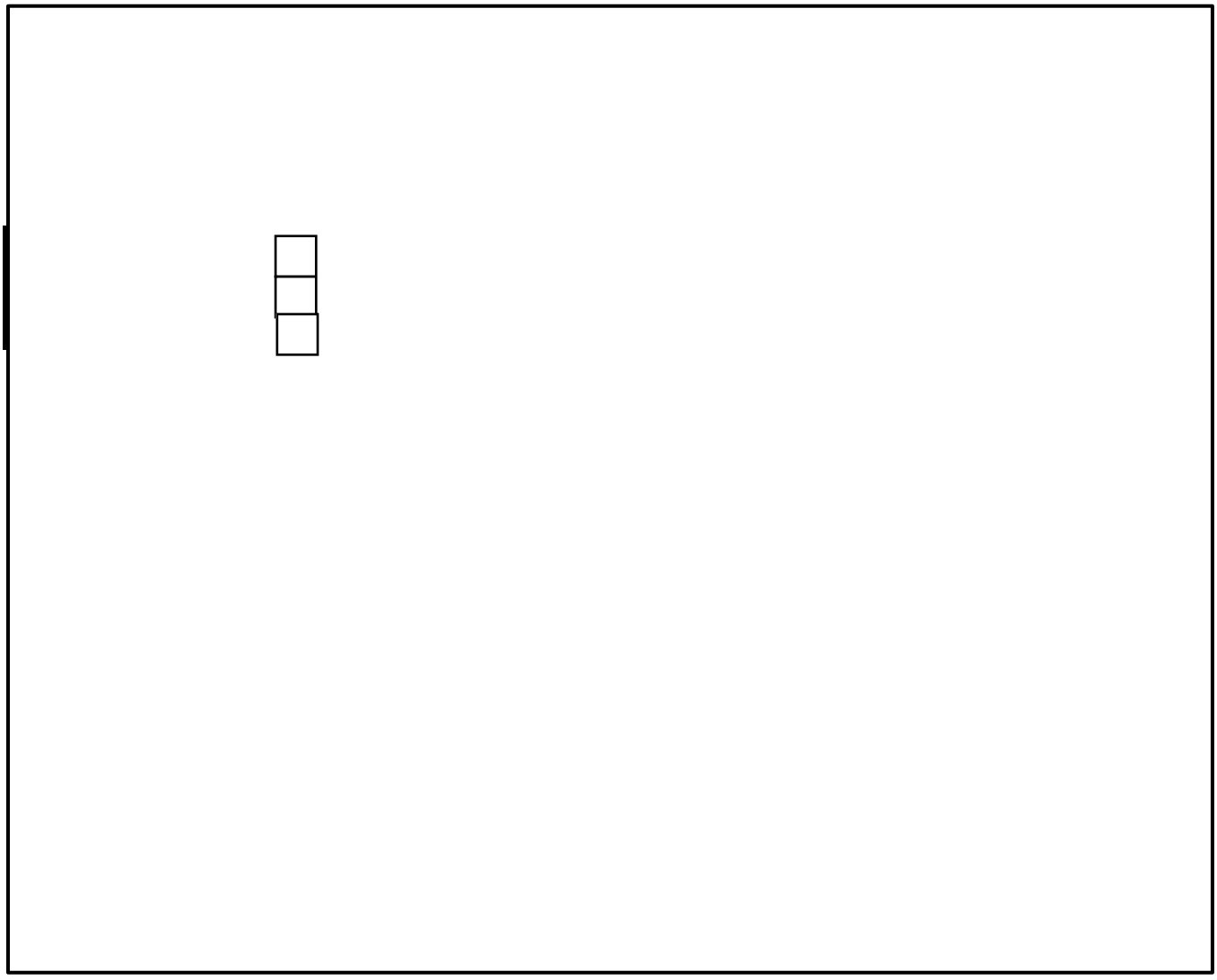
accommodations for students with diagnosed disab
to provide documentation that identifies a diagnose
504 of the Rehabilitation Act of 1973 and Title II of t
(ADA) of 1990.

DRC requires current and comprehensive documen
appropriate services and accommodations. The out
assist the student in working with the treating or dia
obtaining the specific information necessary to evalu
accommodations.

The healthcare professional(s) conducting the assessment and/or

Forms must be completed as thoroughly as possible
incomplete answers and/or illegible handwriting will
up contact with the healthcare professional.

The healthcare provider should attach any reports w
information (e.g. psycho-educational testing, neurop
comprehensive diagnostic report is available that pr



4. In addition to DSM-V criteria, how did you arrive at your diagnosis?

- ‘ Structured or unstructured interviews with the student
- ‘ Interviews with other persons
- ‘ Behavioral observations
- ‘ Developmental history
- ‘ Educational history
- ‘ Medical history
- ‘ Neuro-psychological testing. Date(s) of testing? _____
- ‘ Psycho-educational testing. Date(s) of testing? _____
- ‘ Standardized or non-standardized rating scales Other. (Please specify)
  _____

5. What is the severity of the disorder? L Mild L Moderate L Severe

Please describe the severity circled above:

_____
_____
_____
_____
_____

6. What is the expected duration of this disability?

_____
_____
_____
_____
_____

10. Describe any situations or environmental conditions that might lead to an exacerbation of the condition.

11. Is this student currently receiving therapy or counseling?

L Yes L No L Not Sure

12. What medications is the student currently taking? How effective is the medication? How might side effects, if any, affect the student's academic performance?

13. Please state specific suggestions regarding academic accommodations for this student, and a rationale as to why these accommodations/adjustments/services are warranted based upon the student's functional limitations. Indicate why the accommodations are necessary.

14. If the current treatments (i.e. Medications and therapy) are successful, state the reasons the above academic adjustments, auxiliary aids, and/or services are necessary.

_____

_____

_____

_____

_____

_____

HEALTHCARE PROVIDER INFORMATION

Provider Signature: _____ Date: _____

Provider Name (Print): _____

Title: _____ License or Certification #: _____

Address: _____

_____

Phone Number: (_____)-_____-_____

FAX Number: (_____)-_____-_____

The information you provide will not become part of the student's academic records, but it will be kept in the student's file at DRC, where it will be held strictly confidential. Files are purged after 7 years in compliance with state requirements. This form may be released to the student at his/her request.