

**Housatonic Community College  
Office of Disability Services  
Psychiatric Documentation**

Your client, \_\_\_\_\_, has disclosed his/her psychiatric disorder to the Office of Disability Services. The following information is required to validate this diagnosis and to determine the nature of appropriate and reasonable academic accommodations. This document must reflect the current impact on the student's academic functioning and support the requested accommodation(s) and/or auxiliary aid (s). Failure to provide this information will result in a delay or inability to provide the services. This College reserves the right to determine the nature and extent of reasonable and appropriate academic accommodations.

I. Current Medical Information

A. DSM-IV Diagnosis: \_\_\_\_\_

\_\_\_\_\_

B. Date of last appointment with undersigned professional: \_\_\_\_\_

C. Initial onset of symptoms: \_\_\_\_\_

\_\_\_\_\_

D. Description of present symptoms: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

E. Relevant historical and family data: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

F. Treatment plan with medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

G. Prognosis and expected duration of treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

H. Additional pertinent medical information with attached assessment tools and/or education testing with standardized scores: \_\_\_\_\_

---

---

---

---

II. Impact of Diagnosis in Education Setting

A. Current Functional academic limitations (please be specific): \_\_\_\_\_

---

---

---

---

B. Recommendations for academic accommodations that are realistic and validated by current documentation: \_\_\_\_\_

---

---

Additional Comments \_\_\_\_\_

---

---

---

**This information may be given to your client to submit to this Office, or you may forward it to the following:**

**Lynne Langella  
Coordinator of Disability Support Services  
Housatonic Community College  
900 Lafayette Blvd.  
Bridgeport, CT 06604**

**Questions or concerns may be directed to Lynne Langella at (203) 332-5018**

\_\_\_\_\_  
Name of professional (please print) Title Date

\_\_\_\_\_  
Signature Telephone Number

\_\_\_\_\_  
Street Address City/State/Zip Code