Northeastern University

DISABILITY RESOURCE CENTER

360 Huntington Ave, **20 Dodge Hall**, Boston, MA 02115

Disclosure Form – Information for clinicians

You are receiving the attached Disability Disclosure Form for Attention Deficit Hyperactivity Disorder (ADHD) and Psychiatric Disorders because a student under your care is requesting accommodations from the Disability Resource Center (DRC) at Northeastern University.

A diagnosis of an Attention Deficit Hyperactivity Disorder (ADHD) and/or a psychiatric disorder does not, in and of itself, qualify a student for accommodations under the ADAAA. Accommodations are not based on the student's diagnosis, but instead are designed to address the barrier(s) caused by any substantial limitation(s) related to the disorder. Accommodations are meant to allow full participation in academic and university life for students with disabilities; they do not guarantee student success. The DRC uses a multi-source process to determine eligibility for disability-related accommodations, which includes self-report, history of accommodations (when available), and clinical observations. This form is intended to provide us with the latter.

Please note that the information you provide in response to the questions on this form must be current; in general, you must have seen the student within the last 6 months to meet this requirement. If you have recently begun treating this student, you may find that you do not yet have sufficient information to respond to the questions on this form. If you have not had recent clinical contact with the student, or otherwise find that you cannot effectively complete this form, please inform the student directly.

If you have questions or concerns about this form, how the information is used, or how best to support the student, we invite you to contact our office, at 617.373.2675 or email DRCDocumentation@northeastern.edu.

Website: www.northeastern.edu/drc * Phone: (617) 373 2675 * Fax: (617) 373 7800*

Disclosure Form – Student authorization to clinician

Dear _____:
Clinician name

I am requesting accommodations from the Disability Resource Center (DRC) at Northeastern University. One element of the process for requesting accommodations is the submission of the Disclosure Form by my treating clinician. The Disclosure Form is attached, along with an explanation of its use and instructions for completion.

☐ I hereby authorize you to complete the attached Disclosure Form and release it to the DRC.

☐ I also authorize you to speak with the staff of the DRC to provide consultation concerning the requested accommodations.

Please submit the completed form by mail to:

Disability Resource Center
20 Dodge Hall
Northeastern University
360 Huntington Avenue
Boston, MA 02115

Or by confidential fax: 617-373-7800
Or by email: DRCDocumentation@northeastern.edu

Thank you for your timely assistance with this matter.

Sincerely,

_____ _____
Student Signature Date

_____ _____
Print Name NUID

Northeastern University

DISABILITY RESOURCE CENTER

360 Huntington Ave, **20 Dodge Hall**, Boston, MA 02115

Disability Disclosure Form

Attention Deficit Hyperactivity Disorder (ADHD) and Psychiatric Disorders

Instructions for using this form:

- Please read the attached **"Information for clinician"** cover sheet before completing this form.
- This form is to be filled out by the clinician **currently treating** the student for the diagnosis(es) identified below.
- In general, you must have seen the student **within the last 6 months** to meet our standards for current documentation.
- **If you have recently begun treating this student**, you may find that you do not yet have sufficient information to respond to the questions on this form.
- **If you have not had recent clinical contact with the student**, or otherwise find that you cannot effectively complete this form, please inform the student directly.

1. **Patient's/Client's name**: _____
2. **Diagnosis(es)**: _____
3. **Please provide full DSM or ICD-10 code(s)**: _____
4. **Initial date of diagnosis**: _____
5. **When did you first start treating this student?** _____
6. **How frequently do you meet with this student?**

   ☐ weekly ☐ monthly ☐ yearly ☐ other: _____
7. **Date of last clinical contact**: _____
8. **What is the frequency of the disorders' symptoms for this student?**

   ☐ ongoing ☐ episodic (Please indicate frequency and duration below)
9. **The extent of the impairment is**: ☐ Mild ☐ Moderate ☐ Severe
10. **Assessment**: How did you arrive at the diagnosis? Please check the relevant options below.

    ☐ Structured or unstructured interview with student or others (e.g., parents, teachers)
    ☐ Behavioral observations
    ☐ Neuropsychological testing (please attach results)
    ☐ Rating scales (please attach results)
    ☐ Other (please name):_____

11. If relevant, please describe the student's history of difficulties with attention and/or executive functioning (include age of first symptoms, childhood symptoms, and impact).

12. If relevant, please describe the student's academic history, including how the disability has impacted learning in the past.

10. Treatment: Please describe the current treatment and medication regimen. Include information about any significant medication side effects the student is experiencing.

11. Substantial limitations affecting academics

To aid in our determination of whether the student is substantially limited in the academic setting, we ask that you provide information about how the student's symptoms impact him/her on tasks including, but not limited to:

paying attention to lecture · taking notes · responding to questions · taking exams · participating in group work · following instructions · organizing work

Please check those areas in which the student's symptoms cause limitations, and provide a description of the impact experienced by the student on academic settings and tasks.

	Area of substantial limitation	***Please describe current impact on this student***
☐	**Concentration or attention**	
☐	**Planning and organizing**	
☐	**Initiating and sustaining effort**	
☐	**Accessing or utilizing memory**	
☐	**Self-monitoring actions**	
☐	**Learning**	
☐	**Other:**	

12. Substantial limitations affecting campus life

To aid in our determination of whether the student is substantially limited in areas outside of academics, we ask that you provide information about how the student's symptoms impact him/her in campus life (e.g., residence halls, peer interactions). Please consider, as relevant, the influence on tasks including, but not limited to:

self/personal care · interactions with roommates/peers · stamina and fatigue

Please check those areas in which the student's symptoms cause limitations, and provide a description of the impact experienced by the student on non-academic settings and tasks.

	Area of substantial limitation	***Please describe current impact on this student***
☐	**Emotional regulation**	
☐	**Sleeping**	
☐	**Social functioning**	
☐	**Stamina**	
☐	**Other:**	
☐	**Other:**	

13. Additional information: Please provide any additional information you think will be helpful in determining reasonable accommodations for this student.

14. Annual update: You may be asked to update this form annually in order to confirm that the student continues to meet the diagnostic criteria for the given diagnosis(es) and to experience the substantial limitations described here. If your assessment of the student suggests that the condition is stable and will not require updates, please explain here:

15. Certification

Clinician's name: _____

Clinician's state licensure/certification #: _____

Area of specialty: _____ Clinician's phone #: _____

_____ _____

Clinician's signature Date