Date ________________________________

Dear Dr. ____________________________________

Your patient, __________________________________, has requested accommodations through the Disability and Learning Resource Center at Concordia University, Irvine. In order to provide reasonable accommodations we require documentation of the specific functional limitations that result from the individual’s disorder and/or medication side effects. General statements about the disorder or medication do not help determine appropriate accommodations. The purpose of the functional limitations is to indicate how a specific disorder “substantially interferes with a major life activity, such as working or learning.” Please respond in full to the following questions:

1. What is the multi-axial DSM-IV classification?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

2. What historic data was taken into account in making the diagnosis?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

3. What were the assessment or evaluation procedures used to make this diagnosis?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

4. Please indicate the major symptoms of the disorder currently manifested by the student, including level of severity:

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<tr>
<th>SYMPTOM</th>
<th>LEVEL OF SEVERITY</th>
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<td>Mild</td>
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5. What medications are currently prescribed? Are there any side effects, and if so, how severe?

__________________________________________________________________________________________________________________________________________________________

6. Is the individual currently in treatment with you, and if so, when did you last see him or her?

__________________________________________________________________________________________________________________________________________________________

7. What is the progress?

__________________________________________________________________________________________________________________________________________________________

8. What are the current functional limitations imposed by the disorder? (e.g. difficulty: switching modalities, managing time or deadlines, formulating or executing a plan of action, taking notes, focusing during timed tests, tolerating interruptions, focusing for extended class period; easily distractible/poor concentration; panicking in crowded conditions/surroundings)

__________________________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________________________

Name of Physician ____________________________ Lic.# ____________________________
Signature ___________________________________ Date _____________________________
Phone ______________________________________ Fax _____________________________
Address ___________________________________________________________________________

Thank you for your assistance. If you have further questions, please do not hesitate to contact the Disability and Learning Resource Center.

Terilyn Jackson
Director of Disability & Learning Services
Concordia University, Irvine
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1530 Concordia West, Irvine CA 92612
Tel/Fax (949) 214-3039