Medical/Psychological Disability Summary Report Form*
(*To accompany or supplement medical documentation/psychological report)

Student Name: __________________________ ID Number: ____________________

Student Email Address: __________________________

The above-mentioned student has requested academic accommodations from the Office of Disability Services (ODS) at Texas State University on the basis of a psychological disability, acquired brain injury, medical disability or Attention Deficit/Hyperactivity Disorder. In order to determine whether the student qualifies for services based on university criteria, the following information is needed now, and may be required as an update every twelve months. Please return the completed form to the address above.

1. How long has this patient been under your care? __________________________

2. Basis for diagnosis (check all that apply):

   _____interview   _____therapy   _____history

   _____psychological tests (please list)   _____other (please specify below)

3. Onset and anticipated duration of diagnosis: __________________________

4. University criteria requires the evaluation include a multiaxial diagnosis according to the diagnostic codes established in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV). Accommodations cannot be granted without a DSM diagnosis. Please identify the primary and secondary DSM diagnosis for this student:

   Axis I: __________________________   Axis III: __________________________

   __________________________   Axis IV: __________________________

   Axis II: __________________________   Axis V: __________________________

OFFICE OF DISABILITY SERVICES
601 University Drive | LBJ Student Center 5-5.1 | San Marcos, Texas 78666-4616
phone: 512.245.3451 | fax: 512.245.3452 | www.txstate.edu
This letter is an electronic communication from Texas State University.

MEMBER THE TEXAS STATE UNIVERSITY SYSTEM
5. How is the student’s learning impaired by their disability (check all that apply)?

- attention span
- distractibility
- memory
- processing speed
- abstract thinking
- concentration
- sustained vigilance
- other (please specify)

6. What academic accommodations would you recommend for this student (check all that apply)?

- extended time on exams
- reduced distraction environment for testing
- seating in front of classroom
- advance registration of classes
- reduced course load
- other (please specify below)

7. For what time period (e.g., 12 months) are academic accommodations recommended?


8. Do you recommend the student continue under your care and/or seek on-going treatment of any type? If so, please explain:


Certifying Professional (please print or type)

Name ___________________________ License # ___________________________
Address ___________________________ Phone ___________________________
________________________________ Date ___________________________

Signature ___________________________

Thank you for your time and prompt reply so that we may begin services as soon as possible. If you have questions or need additional information, please contact the following ODS staff member at 512-245-3451.