CAAS

Center for Access and Accommodative Services

Center for Access and Accommodative Services
Triton College
2000 Fifth Ave., River Grove, IL 60171, Room A-125
Phone: (708) 456-0300, Ext. 3853 or 3854, Fax: (708) 456-0991

PSYCHIATRIC DISABILITY DOCUMENTATION

The student, whose name and signature appear below, has requested accommodative services based on the diagnosis of a psychiatric disability or condition. Students requesting services from the Triton College Center for Access and Accommodative Services are required, under Section 504 of the Federal Rehabilitation Act of 1973, to submit documentation to verify eligibility. This form must be completed by a psychiatrist, licensed psychologist or certified social worker (CSW or ACSW). **Please complete and return this form in a sealed envelope or by fax to the attention of C.A.A.S.**

Please note: Accommodations will be provided only upon receipt of complete and adequate documentation.

Student Name **Signature** **Birth Date**

Professional Credentials

Professional Name **Title** **Office Phone**

Office Address

License/Certification Number & State of License

DSM/ICD CODE (S)
Diagnosis/Diagnostic code:

DSM/ICD CODE (S)	DIAGNOSIS

Date of initial contact _____ **Date of Diagnosis** _____

Is this person currently receiving regular counseling? How frequently?

Vocational, social interpersonal impact.

Level of current functioning (even with benefits of treatment, GAF score)

Impairment of learning abilities
(difficulty with concentration, memory, slow processing speed, etc.)

Does this person pose a threat to themselves or others (explain)?

Current medications:

MEDICATION	DIAGNOSIS	SIDE EFFECTS

Is the client compliant with their medication and medical plan?

History of Hospitalization(s):

Recommendation for Accommodation and/or Support Services:
Indicate which, if any, of the accommodations listed below would be appropriate:

_____ **Notetakers to supplement this student's notes**
_____ **Extended time on exams**
_____ **Distraction free testing environment**
_____ **Test read aloud**
_____ **Recording of lectures**
_____ **Other (please specify):** _____

I RECOMMEND THE FOLLOWING COURSE LOAD:					
	Minimal part time		**Part time**		**Full time**
_____	**1 Class**	_____	**2-3 Classes**	_____	**4-6 Classes**
_____	**Approximately 3-5 credit hours**	_____	**Approximately 6-9 credit hours**	_____	**Approximately 12-15 credit hours**

Restrictions:

I certify that the above stated information is correct based on my professional judgment.

Signed _____ **Date:** _____