PART I TO BE COMPLETED BY EVALUATOR

DISABILITY SERVICES – LOUISIANA STATE UNIVERSITY

PSYCHOLOGICAL DISABILITY DOCUMENTATION REQUEST FORM

Student’s Name:  _______________________________________________________________________________
Phone Number:  ___________________________________ Date of Birth: ____________________________
When did/will you start attending LSU?  Semester_______________________  Year: _______________________
LSU I.D. Number: ____________________________ LSU Email: _____________________________________

This student is requesting an auxiliary aid or service, academic adjustment, and/or other accommodations from Disability Services. In order to consider this request, as well as to ensure the provision of reasonable and appropriate auxiliary aids and services, university policy requires that a qualified professional provide current and comprehensive documentation. A qualified professional is a licensed mental health professional who is not a family member of the student.

**** This form must contain ALL of the requested information below in order to apply for accommodations through Disability Services. ****

1. Diagnosis (as diagnosed by the DSM-5):  ________________________________________________________

2. Date of Diagnosis:______________________   Date of Last Contact  with Student:  _____________________

3. Provide a summary of the student’s educational, medical, and family history that relates to the psychological disability (difficulties must be related to the diagnosed disability and are not the result of other conditions, cultural differences, or insufficient instruction):  ____________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________

4. Describe the student’s functional limitations (i.e., current and/or anticipated problems associated with the condition) in an educational setting:  ____________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
5. List **current medication** along with any **current side effects** that may impact academic performance: 

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

6. Please indicate below the **RECOMMENDATIONS** you have regarding necessary and appropriate auxiliary aids or services or other accommodations to equalize the student’s educational opportunities at LSU as justified based on the functional limitations indicated above.

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Qualified Professional’s Signature: ______________________________________________________________

Printed Name & Title: _________________________________________________________________________

License or Certification Number: __________________________________________________________________

Daytime Telephone Number: ____________________________________________________________________

Address:  _____________________________________________________________________________________

Date: ________________________________________________________________________________________

Disability Services  
Louisiana State University  
124 Johnston Hall  
Baton Rouge, LA 70803  
Phone: 225-578-5919  
Fax: 225-578-4560  
Email:disability@lsu.edu
PART II TO BE COMPLETED BY STUDENT

DISABILITY SERVICES – LOUISIANA STATE UNIVERSITY

REQUEST FOR ACCOMMODATIONS

Student’s Name: _______________________________________________________________

Phone Number: ____________________________ Date of Birth: __________________________

When did/will you start attending LSU? Semester __________________ Year: ____________

LSU I.D. Number: ____________________________ LSU Email: ____________________________

LSU enrollment for which you are requesting accommodations (check below):
- LSU A&M (Main Campus)
- LSU Law Center
- Vet School
- LSU Online
- Independent and Distance Learning (Enrollment #) __________________

I am requesting accommodations because I have been diagnosed with one or more of the following disabilities which functionally impairs my ability to perform in an academic environment (check all that apply):

Attention Deficit Hyperactivity Disorder (ADHD)

Learning Disability

Deaf & Hard of Hearing

Psychological Disability (specify): ________________________________________________

Physical or Medical Disability (specify): ___________________________________________

Temporary Disability (specify): _________________________________________________

In the space below, please list and explain the reason for each of the accommodations you are requesting.

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

Signature of Student: ____________________________ Date: ____________________________

*Please note: Disability Services strongly recommends maintaining copies of any submitted documentation for personal records.
CONSENT TO RELEASE

I, __________________________________________(student/incoming student), understand that the information contained in my record is confidential. However, I give my consent for

DISABILITY SERVICES

to release to ________________________________________________(parent, guardian, other)

the following specific information: DISABILITY AND ACADEMIC

The above-listed information is to be disclosed for the specific purpose of

ACCOMMODATIONS and UNIVERSITY SUPPORTS.

This consent is subject to written revocation OR cancellation signature at any time except to the extent that action has already been taken upon this consent. All releases are done on roughly an annual basis regardless of any date changes to the form with all releases expiring at the end of the upcoming academic year.

This consent will automatically expire AUGUST 20, 2021.

____________________________
Signature of Student/Client

____________________________
LSU ID#

____________________________
Date

I wish to cancel this Consent to Release effective _______________________.

Date

____________________________
Signature of Student/Client