TEXAS STATE ®
DISABILITY SERVICES

Disability Summary Report Form

Student Name:_____ Student Date of Birth:_____

The above-mentioned student has requested academic accommodations from the Office of Disability Services (ODS) at Texas State University on the basis of disability. In order to determine whether the student qualifies for services, we ask that you as the health care provider please provide the following information. Once completed, please return the completed form to the Office of Disability Services.

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1. Please identify all diagnoses for this student, provide the corresponding codes from either the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) or International Statistical Classification of Diseases and Related Health Problems (ICD-10), and indicate the date of diagnosis.

Code and Diagnosis Name	Date of Diagnosis

2. Date of first contact with student:_____
   Month/Day/Year

3. Date of last contact with student:_____
   Month/Day/Year

4. List any side effects related to treatment or medications:

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.ODS.TXSTATE.EDU
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5. Describe the student's current functional limitations and the impact they have on the student in the educational environment.

6. Indicate the academic accommodations that you are recommending and why they are necessary. Recommendations must be clearly linked to the functional limitations of the student's condition(s).

7. If applicable, indicate the housing and/or dining accommodations that you are recommending and why they are necessary. Recommendations must be clearly linked to the functional limitations of the student's condition(s).

8. If available, please attach copies of complete medical records, psychiatric records, and/or psychological reports to this form.

Certifying Professional – **By signing below (print/type), you are confirming that you are the qualified healthcare professional who is providing the information above.**

Name:_____ License #:_____

Address:_____ Phone:_____

_____

_____

Signature: _____ Date:_____

Please fax the completed form to the Office of Disability Services at 512.245.3452. If you have any questions, feel free to contact our office. Thank you.