TEXAS STATE UNIVERSITY
Disability Services

Disability Summary Report Form

Student: By signing below (print/type), you consent to allowing your healthcare professional to share information relevant to your need for accommodations with personnel from Disability Services at Texas State.

Student Name _____ Student Date of Birth _____

To be completed by a certifying professional: To determine whether the above-named student qualifies for services, we ask that you as the health care provider please provide the following information.

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:

DISABILITY SERVICES
601 University Drive | LBJ Student Center 506 | San Marcos, Texas 78666-4616
phone: 512.245.3451 | *disability.txst.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). If none, write N/A.

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

_____ Printed Name of Person/Provider	_____ License Number
_____ Street Adress/P.O. Box Number/Agency/Department	(___ ___ ___)___ ___ ___ -___ ___ ___ ___ Telephone
_____ City, State, Zip Code	(___ ___ ___)___ ___ ___ -___ ___ ___ ___ Fax
_____ Signature	_____ Date

By signing (print/type), you are confirming that you are the qualified healthcare professional who is providing the information above. Please return the completed form to Disability Services or to the aforementioned-student. If you have any questions, feel free to contact our office at 512-245-3451 or at disability@txstate.edu. Thank you.