Documentation Form
CSP Disability Services
Youngstown State University
Office: 330-941-1372
Fax: 330-941-7470

(Please type or print this Form)
Client/Patient's Name ______________________________________ **ID# Y00**________________

Name and Credentials of Professional treating student for disability:

____

Phone # ____

Signature ____

Date: ____

Diagnosis: (*Please give a full clinical description***). DSM/ ICD #** ____________ **(if appropriate)**
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____

When and how was the person first diagnosed? What evaluation methods/procedures were used to diagnose the person?
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____

Will the person's disability progressively get worse? If yes please explain.
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How does the person's disability affect his/her daily life?
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____
____

Medications the person is currently taking:
____
____

Continued on Back

Academic accommodations recommended?

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____
____

Comments or Suggestions:

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