Tufts University promotes an accessible college experience for all students, including those who are navigating mental health diagnoses. Tufts views mental health diagnoses as a disability that is persistent in its effects and impacts one or more major life function. Examples may include but are not limited to: anxiety, depression, bi-polar disorder, obsessive compulsive disorder, schizophrenia, multi-personality disorder, eating disorders, etc. Accommodations are designed to address the barriers caused by the substantial limitation(s) related to the mental health disability and allow the student full participation within the Tufts community.

Use this form to provide information for a Tufts student who has requested an accommodation/modification for a mental health disability(ies). The information that you provide will be used to better understand the nature, severity and treatment plan for the student’s diagnosis and the appropriateness of requested accommodations or services. Please note that the information you provide must be current; in general, you must have seen the student within the last 6 months to meet this requirement. If you have recently begun treating this student you may find that you do not yet have sufficient information to respond to the questions on this form. If you have not had recent clinical contact with the student, or otherwise find that you cannot effectively complete this form, please inform the student directly. Please make sure to complete this form in its entirety. All information provided may be shared with the student, but is otherwise confidential per the Family Educational Rights and Privacy Act (FERPA). If you require a signed consent for release of information, please communicate that with the student prior to releasing their information.

If you have questions regarding the information being requested in this form, please contact:
Katherine H. Vosker
Director of Student Affairs
Tufts University School of Dental Medicine
1 Kneeland Street, Room 1511D
Boston, MA 02111
(617)636-0887
katherine.vosker@tufts.edu

**Student Information:**

Name of student:
________________________________________________________________

Student email address:
________________________________________________________________

Student phone number:
________________________________________________________________

**Current Healthcare Provider Information:**

Name of healthcare provider:
________________________________________________________________

Degree/Specialty:
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

Phone number:
________________________________________________________________
Address:

____________________________________________________________

License #/State(s) licensed in:

____________________________________________________________

**Information about the Mental Health Disability:**

Diagnosis (List all relevant diagnoses):

____________________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

Please provide the full DSM or ICD-10 code:

____________________________________________________________

Initial date of diagnosis:

____________________________________________________________

Date of your last clinical contact with the student:

____________________________________________________________
Severity of symptoms with mitigation:

- Mild
- Moderate
- Severe

Severity of symptoms *without* mitigation:

- Mild
- Moderate
- Severe

What is the frequency and duration of symptoms of the student’s condition?:

- Ongoing
- Episodic

If symptoms are episodic, please indicate frequency and duration:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Please describe the student’s history of difficulties with their disability. Include both general and academic areas of impact.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Please describe the substantially limiting symptoms which impacts this individual's functional as well as academic and clinical abilities (consider the higher education environment which includes but is not limited to the classroom, navigating campus, assignments, laboratory and clinical environments, etc.).

Current treatment and medication regiment (including treating clinicians, frequency of treatment, medications, and side effects):

Prognosis of mental health disability w/ treatment:

- Good
- Fair
- Poor
Based on your clinical evaluation, what accommodations do you think this student will need to be an active member of Tufts Dental School while they navigate this disability?

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

Will you be seeing the student again for their disability?

☐ Yes

☐ No

If yes, when is your next scheduled appointment?

________________________________________________________________

Please provide any additional information that you feel will be useful in determining the nature and severity of the student’s disability, and any additional recommendations for other resources the student will benefit from as they navigate their disability.

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

Please type your initials below. By doing so, you certify that you are the person listed as completing this form, and you verify that you are not related to the student by blood or marriage. You also confirm that all information you have provided is accurate and up-to-date.

________________________________________________________________
Date this form was completed:


