PSYCHOLOGICAL OR PSYCHIATRIC EVALUATION FORM – REQUEST FOR ASSISTANCE ANIMAL IN THE RESIDENCE HALL

Students with psychiatric disabilities who request the assistance of an emotional support animal or assistance animal may request an accommodation through the Office of Accessibility Resources (OAR). Requests for housing accommodations are also reviewed by Residence Life based upon necessity to ensure equal access to the housing program. This form must be completed by the student’s treating psychiatrist, clinical psychologist, clinical social worker, or other mental health professional qualified to make psychological or psychiatric diagnoses.

Directions to Students:
• Complete Part I
• Sign the Consent for Release of Information
• Provide the form to your qualified treatment provider to complete Part II
• Return the entire form to OAR in accordance with the Policy.

Part I: Student to complete the following

Please print clearly

Student’s Full Name: _____________________________________________________________________

Student ID#:
___________________________________________________________________________________

Student Telephone #:
___________________________________________________________________________________

Student Email Address:
___________________________________________________________________________________

Status/Campus:  □ Freshman □ Sophomore □ Junior □ Senior □ Transfer

Accommodation Request is for: YEAR_____ □ Fall □ Spring □ Summer

Part II: Physician or Evaluator Verification
Directions: Please print clearly or type. Please answer all questions thoroughly. Insufficient documentation may result in accommodation delays or denial.

Is the student currently under your care?  YES _____  NO _____

Are you the prescriber of the emotional support animal?  YES _____  NO _____

If yes, when did you prescribe the emotional support animal? (mm/dd/yyyy) ____________

How long has the student had an emotional support animal? ________________________

What type of emotional support animal did you recommend? ________________________

Is the request an integral component of a treatment plan for the condition in question?  YES _____  NO _____

Describe the student’s functional limitations or behavioral manifestations caused by the condition. What do you foresee as the impact living in a college residential hall setting?

___________________________________________________________________________

___________________________________________________________________________

Please explain how the emotional support animal ameliorates the effects of the disability:

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Would you consider other accommodations to be a reasonable alternative to an emotional support animal (i.e., single room, preference in choosing housing assignment, other)? Please explain:

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Is there a negative health impact that may be permanent if the request is not met?  YES _____  NO _____

What is the likely impact on academic performance if the request is not met?
What is the likely impact on social development if the request is not met?

________________________________________

What is the likely impact on the student’s level of comfort if the request is not met?

________________________________________

THIS SECTION MUST BE COMPLETE FOR FORM TO BE VALID

Physician or Evaluator’s INFORMATION (Please Print)

Name: __________________________________________________________

Title: ___________________________ Specialty: ______________________

Office Address: __________________________________________________

Phone: __________________________

License/Certification Number and State of License _______________________

How long have you treated this patient? ________________________________

Date of most recent office visit? _____________________________________

May we contact you if we have questions about this student’s accommodation request?

Yes _____ No ______

Signature: ___________________________ Date: ______________

PLEASE MAIL, FAX or EMAIL COMPLETED FORM TO:

Drew University
Office of Accessibility Resources
36 Madison Avenue
Madison, New Jersey 07940
Office: (973) 408-3962
Fax: (973) 408-3768
Email: dgioux@drew.edu