Documentation Guidelines for Psychiatric Disabilities
Quick Reference Guide

ETS is committed to serving test takers with disabilities or health-related needs by providing services and reasonable accommodations that are appropriate given the purpose of the test. This abbreviated version of our documentation guidelines for psychiatric disorders is provided as a quick reference. For full details, please review the ETS *Guidelines for Documentation of Psychiatric Disabilities in Adolescents and Adults* at ***http://www.ets.org/disabilities/documentation/***.

Documentation must:

- **Be completed by a qualified evaluator.**
  Qualified evaluators are defined as those licensed individuals who are competent to evaluate and diagnose psychiatric disabilities. The name, title and professional credentials of the evaluator should be included on letterhead, typed in English, dated, and signed. The qualified professional's training, expertise in the diagnosis of psychiatric disabilities, and appropriate licensure/certification are also essential. See section I of the guidelines.
- **Include test taker's identifying information (full name and date of birth).**
  See section I of the guidelines.
- **Be current.**
  Documentation needs to be from an evaluation that was conducted or updated within the last twelve months. See section III of the guidelines.
  A documentation update for psychiatric disabilities is a report or a narrative by a qualified professional that includes a summary of the previous disability documentation findings as well as additional clinical and observational data to establish the candidate's current need for the requested testing accommodations. See section III of the guidelines.
- **Include a comprehensive history.**
  Include a comprehensive history of presenting problems associated with the disability as well as information on the test taker's medical, developmental, educational, employment, and family history. This should also include the date of onset, duration, and severity of the disorder. See section II, A of the guidelines.
- **Include relevant observations of behavior.**
  Behavioral observations, combined with the clinician's professional judgment and expertise, are often critical in helping to formulate a diagnostic impression. See section II, A of the guidelines.
- **Provide specific diagnosis/diagnoses.**
  The report must include at least one specific diagnosis based on the DSM-5 or the ICD-10, preferably listed in a specific diagnostic section of the report with the nominal diagnosis and accompanying numerical code. See section II, B of the guidelines.
- **Include information about psychotropic medication management and side effects.**
  If the test taker is being treated with psychotropic medication, include the name of each specific agent, dosing regimen, and any actual side effects experienced by this individual. See section IV of the guidelines.

- **Include specific recommendations with a rationale based on objective evidence.**
  Establish a link between the requested accommodations and the manifested symptoms of the disorder that is pertinent to the anticipated testing situation. See section V of the guidelines.
- **Include additional sources of information if appropriate.**
  A personal statement from the test taker in his/her own words explaining academic difficulties and coping strategies used may be helpful. See section VII of the guidelines.