Atlanta Metropolitan State College
1630 Metropolitan Parkway, SW
Atlanta, GA 30310

Department of Counseling and Support Services

INTAKE FORM

Today's Date_____

Student _____
(Last Name) (First Name)

SSN/Student ID #_____ Semester/Year_____
Male____ Female_____ Date of Birth_____ Age_____

Current Address _____

Phone: _____ O.K. to leave message on answering machine _____
E-mail: _____

Current Marital Status: _____ Spouse's Name (if applicable)_____
Number of Dependents_____ Ages_____

Academic Class (Please check)
Freshmen_____ Sophomore_____
Major_____

Referral Source: Self_____ Other (please specify)_____

Emergency Contact
Name_____ Relation_____ Phone #_____

Your Permanent Address_____
_____

Reason for seeking counseling: _____
_____
_____

Physical/Emotional History
Are you now under a doctor's care?_____If yes, name of doctor_____

Are you taking any medication?_____If yes, what kind?_____

Have you been treated for emotional disturbances?_____If yes, when?_____

Have you had any thoughts of suicide?____If so, when_____ Do you have any thoughts now?_____

Atlanta Metropolitan State College

Department of Counseling and Support Services
1630 Metropolitan Pkwy, SW/ Atlanta, GA 30310-4498/ (404) 756-4016/ Fax (404) 756-4939

INFORMED CONSENT FOR COUNSELING SERVICES

_____	_____	_____	_____	_____
Last Name	***First Name***	***Middle Initial***	***AMSC ID***	***Date***

Introduction

Welcome to the Counseling and Disability Services Center at Atlanta Metropolitan State College. This informed consent document is intended to give you general information about our counseling services. This is a legal document; please read it carefully before signing. If you have any questions about signing this document and/or would like a copy of this document, please ask your counselor.

Eligibility

I understand that eligibility for services is contingent upon my status as an enrolled or continuing AMSC student.

Provision of Services

I understand that AMSC offers a variety of services to students including: intake assessment, short term individual counseling (up to 8 sessions per academic year), crisis intervention, workshops and referrals. During the initial assessment, my AMSC counselor and I will work together to determine how best to serve my needs. I further understand that an appropriate referral will be provided to me if it is determined that I would be best serviced by a community resource.

Nature of Counseling

I understand that there may be both risks and benefits associated with participation in counseling. Counseling may improve my ability to relate with others, provide a clearer understand of myself, my values, and my goals, and an ability to deal with everyday stress. I understand that counseling may also lead to unanticipated feelings and change, which might have an unexpected impact on me and my relationships.

Confidentiality

I understand that AMSC counselors maintain confidentiality in accordance with the ethical guidelines and legal requirements of their profession. Effective counseling sometimes requires that staff members share confidential information with other staff members.
I may give AMSC Counseling Staff written permission to share information with others such as; AMSC faculty and administration, family members, or other health care providers. However, I may revoke permission for the AMSC Counseling Center to exchange information with these individuals at my discretion.
I understand that no records or information about me will be released from AMSC without my permission, **except under certain circumstances.**

- If I present a serious danger to myself or another person.
- If my provider suspects that a child, dependent adult or elder is being abused (physically or sexually) or neglected, they are required by law to make a report to the proper authorities.
- If I am under 18 years of age and disclose abuse or neglect to my counselor.
- If a valid subpoena is issued for my records, or my records are otherwise subject to a court order or other legal process requiring disclosures.

Please Note: The exceptions to confidentiality are extremely rare. However, if they should occur it is the Center's policy that, whenever possible, we will discuss with you any action that is being considered. Legally we are not obligated to seek your permission, especially if such a discussion would prevent us from securing your safety or the safety of others. If disclosure of confidential information does become necessary, we will release only the information necessary to protect your and/or another person's physical safety.

Student Initials: ☐

Attendance Policy and Cancellations

I agree that while I am seeing a counselor or participating in a group, whenever possible, I will notify AMSC (by calling 404-756-4016) at least 24 hours in advance if I know I will miss a session. I understand that if I do not show for an individual session and do not call, it will count towards my allotted number of sessions.

Counseling Files

Counseling files are **NOT** part of academic records, and no one has access to them except the staff of the AMSC Counseling Center. Records are kept for the period required by ethical and legal guidelines; that period is presently 7 years.

Contacting Me

In order to keep my relationship with AMSCCC confidential, the best way to contact me should the need arise is noted below. I am aware that information exchanged over a cell phone and e-mail could be intercepted by an outside party.

Okay to leave a message if I am unavailable:	**Please check all that apply**	
	Yes	**No**
Cell Phone: _____	☐	☐
Residential Phone: _____	☐	☐
Work Phone: _____	☐	☐
E-mail Address: _____	☐	☐
Other Phone: _____	☐	☐

If there are any concerns with AMSC Counseling Services that you cannot discuss with your counselor, Please contact the Director of the Counseling and Disability Services at (404) 756-4016.

Consent

I certify that I have read, understand, and agree to abide by the information outlined above regarding my eligibility and use of the College Counseling Services. I hereby give my consent to authorize the College Counseling Services to evaluate, treat, and/or refer me to others as needed. I have had the opportunity to discuss any questions regarding the above information.

_____ _____

Student Signature Date:

ATLANTA · METROPOLITAN · STATE · COLLEGE

Believe · Begin · Become

University System of Georgia

Atlanta Metropolitan State College
1630 Metropolitan Parkway, SW
Atlanta, GA 30310

Department of Counseling and Support Services

AUTHORIZATION FOR RELEASE OF INFORMATION FORM

Student/Client's name (print) _____ DOB ____/____/____

SS# or Student ID #_____

I hereby request and authorize **Atlanta Metropolitan State College** and their designated staff to share information with and to obtain copies of written reports/evaluations from the following:

_____
(Health Care Professional's Name)

_____
(Agency or Health Care Facility)

Written information may include but is not limited to: **Psychological evaluation(s), Psychiatric evaluation(s), Individual Education Plans (IEP)s, all testing, recommendations, school records, medical records, special education records, and any other relevant or requested information for the purpose of determining appropriate treatment recommendations, accommodations, or referrals.**

Other: _____

_____

I authorize the above mentioned entities to share information by phone, in person, fax and/or email contact. I understand that all information will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for the period of time that I am enrolled as a student at Atlanta Metropolitan State College.

I understand that I may withdraw this consent at any time.

_____ _____
Signature of Student Date

_____ _____
Signature and relation of witness Date

_____ _____ _____
Signature of counselor Date

USE THIS SPACE ONLY IF STUDENT/CLIENT WITHDRAWS CONSENT

_____ _____
Signature of Student/Client **Date**

Department of Counseling and Disability Services
Atlanta Metropolitan College
1630 Metropolitan Parkway, SW
Atlanta, Georgia 30310

FERPA RELEASE OF INFORMATION FORM

Student ID #_____

I _____ hereby request and authorize **Atlanta Metropolitan College** and
(First, Middle, Last Name)

their designated staff to share information with _____.
(Parent/Guardian's Name)

Address of Releasee (Parent/Guardian): _____
_____
_____

1. Description of Information to be released:

_____
_____
_____

2. Reason for release of information:

_____
_____

3. Release Information for period of: (Check One)

___ One Semester (Valid from_____ to _____)
___ One Time Use

Other Restrictions and Conditions:

This Consent to Release Records is limited to those persons expressly named herein. Any further release of records/information to any other person, group, corporation or entity of any kind or nature is expressly prohibited without the further written consent of the student. The records listed above will be released in unedited form except as otherwise provided by the Family Educational Rights and Privacy Act of 1974 and regulations promulgated there under applicable state law, and the policies and procedures of the University. THE STUDENT HAS THE RIGHT TO DENY ACCESS TO THE INFORMATION LISTED ABOVE AND/OR TO REVOKE THIS CONSENT AT ANY TIME. In signing this consent form, the student and/or the student's legal guardian agrees to permit the release of information.

I authorize the above mentioned entities to share information by phone, in person, fax and/or email contact. I understand that all information will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for the time period designated and that my consent may be withdrawn at any time.

_____ _____
Signature of Student Date

_____ _____
Signature of Parent or Guardian Date

_____ _____
Signature of Counselor Date

USE THIS SPACE ONLY IF STUDENT/CLIENT WITHDRAWS CONSENT

_____ _____
Signature of Student/Client **Date**

Telephone (404) 756-4783 Facsimile (404) 756-4939

If your request is only for counseling services, STOP HERE.

-OR-

If your request is for both counseling and disability services, complete the entire packet.

Disability Needs Assessment Questionnaire

Directions: It is imperative that you complete and return this form with a copy of your documentation to the Department of Counseling & Disability Services to have accommodations provided in a timely manner. If you wait, your accommodations may not be approved at the beginning of the semester. More information about documentation may be found on subsequent pages of this form.

Please be sure to complete at least two weeks before the beginning of the term. Please return this questionnaire to the Department of Counseling & Disability Services, Room 225 at 1630 Metropolitan Parkway, Atlanta, GA 30310. You may also fax this form to 404-756-4939.

Name: Current Semester:

Street Address:

City: State: Zip Code:

Home Phone: Cell Phone:

E-mail:

1. **In your own words, describe your physical, mental or learning disability.**

2. **List the accommodations you wish Atlanta Metropolitan State College to provide for you during your college career:**

3. **Certain accommodations may require arrangements to be made well in advance. Please contact the Department of Counseling & Disability Services as soon as possible if you check any of the categories listed below. Please attach a separate page to explain the nature of your need.**

□ Campus mobility, including parking

□ Orientation activities or placement testing

□ Curriculum or course selection

□ Class activities, including faculty presentation and testing

□ Special academic equipment or support

□ Dining Services

□ Classroom assignment or class scheduling

4. **In order to process your request for accommodations, Counseling & Disability Services will consult with the following offices as needed:**

□ Enrollment Services □ Student Support Services □ Dining Services □ Student Activities

□ Student Affairs □ Academic Affairs □ Financial Aid □ Academic Advisement Center

We must have your permission to consult with these offices. Please indicate your approval by checking beside each office, and sign and date below.

Signature_____ Date:_____

In the event of an emergency evacuation would you require assistance? □ Yes □ No

Atlanta Metropolitan State College is committed to carrying out the provisions of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973, civil rights laws designed to prohibit discrimination on the basis of disability. The determination to qualify a student as a student with documented disability is made on a case-by-case basis after carefully reviewing how the disability currently and substantially limits a major life activity.

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Department of Counseling and Support Services

Dear Health Care Provider: Date:

Re: _____

The Department of Counseling and Support Services at Atlanta Metropolitan State College (AMSC) coordinates services for students with disabilities. It is the student's responsibility to provide detailed documentation that thoroughly explains the current status of the disability and resulting functional limitations that suggests appropriate academic accommodations.

We request that you please help this student by furnishing as much of the following information as you may have available and as quickly as possible. Only current documentation on letterhead, signed by an appropriate licensed professional (psychiatrist, licensed psychologist, or neurologist) with expertise and training in psychiatric diagnosis can be accepted. In order to meet the Board of Regents criteria for documentation of a psychological disorder, the following information must be included:

- **Diagnosis, including diagnostic codes.**
- **Medications, and side effects, if any, that this person may be experiencing.**
- **Functional impairments/limitations, as a result of the disability and/or medications.**
- **How the impairments/limitations may affect or interfere with academic performance.**
- **IF appropriate to the diagnosis, a copy of previously administered testing and/or psychological evaluations that confirm the diagnosis, especially testing that details: Intellectual Functioning, Academic Achievement, Auditory Processing, Language Skills, Visual Perceptual/Spatial/Motor Skills, Attention, Learning/Memory, Frontal/Executive Functions, and/or Psychological/Psychiatric Disorders.**
- **Evidence that rules out alternative explanations for academic problems, i.e. poor study skills; motivational, emotional, mental, or physical problems; and/or cultural/language differences.**
- ***Suggested* accommodations that may help alleviate the impact on academic performance (refer to the enclosed brochure).**

Thank you for helping us to enhance this student's opportunity for academic success.
To access the Board of Regents criteria for documenting disabilities please refer to http://www.usg.edu/academic_affairs_handbook/section3/C793/. Please contact me for additional information at 404-756-4016. Fax 404-756-4939.

Sincerely,

Dr. Dorothy Williams, LPC
Director, Counseling and Support Services

General Documentation Guidelines

Disability	Currency of Documentation	Accepted Evaluator	Elements of Documentation
1. Documentation must be typewritten on business letterhead from a licensed professional not related to the student who is qualified to give psychological and/or medical diagnosis. The name, credentials and signature of the licensed professional must appear on the documentation. 2. The documentation must include all pertinent diagnoses, clearly stated and explained. 3. Information outlining testing/assessment tools must be included. Learning disability testing must include the actual standard test scores; student must be tested using measures normed on adult populations.			4. Documentation must include information on how the disability currently impacts the individual and document "how a major life activity is limited by providing a clear sense of the severity, frequency and pervasiveness of the conditions(s)" (www.ahead.org/resources/best-practices-resources/elements). 5. All pertinent positive and negative effects of mitigating measures must be addressed. This could include a description of treatment, medications (and potential side effects) and assistive devices with estimated effectiveness of their impact on the disability. 6. Documentation should provide recommendations for accommodations for the individual and include the rationale for the recommended accommodations.
ADD/ADHD	Within 3 years	Psychologist, psychiatrist, neuropsychologist, medical doctor	Evidence of early impairment from more than one setting; evidence of current impairment; summary of neuropsychological or psychoeducational assessments to determine the current functional limitation pertaining to an educational setting; prescribed medications, dosages and schedules; suggestions of accommodation.
Autism spectrum disorder/Asperger's syndrome	Within 3 years	Developmental pediatrician, neurologist, psychiatrist, psychologist, neuropsychologist	Academic testing – standardized achievements test, including standard scores; impact of symptoms on learning; ability to function in a residential college community; prescribed medications, dosages and schedules that may influence the learning environment.
Chronic illness and physical impairment	Depends on condition	Licensed medical professional	Documentation will vary based on the diagnosis, which would include conditions such as asthma, allergies, arthritis, diabetes, fibromyalgia, migraine, and multiple sclerosis.

Disability	Currency of Documentation	Accepted Evaluator	Elements of Documentation
Hearing impairment	Depends on whether condition is static or changing	Otorhinolaryngologist, otologist, licensed audiologist	Audiological evaluation or audiogram administered by a licensed audiologist; interpretation of the functional implications; suggests of accommodations.
Learning disability	Within 3 years	Clinical or educational psychologist, school psychologist, neuropsychologist, learning disabilities specialist	Assessment must be comprehensive (more than one test) and address *intellectual functioning/aptitude*, preferably the Wechsler Adult Intelligence Scale – III with standard scores; achievement – current levels in reading, math, and written language (acceptable instruments include the Woodcock Johnson Psychoeducational Battery III, Wechsler Individual Achievement Test or others); and information processing utilizing subtests from the WAIS-III, WJ III or other. Individual "learning styles"," learning differences"," academic problems" and "test difficulty or anxiety" do not constitute a learning disability. Please refer to General Documentation Guidelines above.
Psychiatric disorder	Current diagnosis within 6 months Psychological evaluation within 3 years	Licensed clinical psychologist, psychiatrist, psychiatric advanced practice registered nurse(APRN), licensed clinical social worker	Family history; discussion of dual diagnosis; current diagnosis (DSW-IV TR) indicates the nature, frequency, severity of symptoms – diagnosis without an explicit listing of current symptoms is not sufficient; prescribed medications, dosages and schedules that may influence the learning environment; types of accommodations, including any possible side effects.
Visual impairment	Depends on condition	Ophthalmologist	Ocular assessment/evaluation; suggestions on how the condition may be accommodated.

Acknowledgement: *This information is based on the Disability Documentation Guidelines to Determine Eligibility for Accommodations at the Postsecondary Level developed by the Georgia Association on Higher Education and Disability as well as the Association on Higher Education and Disability (AHEAD), which is the national organization for postsecondary disability services.*

Atlanta Metropolitan State College
Department of Counseling and Accessibility Services
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ACOMMODATIONS RECOMMENDATION AND REFERRAL FORM

Student/Client's Name _____ **Student ID** _____

Student requires Referral? ___YES / NO_____

REFERRED TO:

Name of Agency:_____

Name of Doctor:_____

Address:_____

Telephone Number:_____

Student's Signature_____ Date_____

Counselor's Signature_____ Date_____

_____ Date _____
Signature: MD/Psychologist/Psychiatrist or Licensed Professional

---

Student Requires Accommodations: ___YES / NO_____

ACCOMMODATIONS:

___ Extended Time on All Exams & Quizzes
___ Testing in a Distraction-Reduced Environment
___ Occasional Exception to Absentee/Tardiness Policy
___ Occasional Extension of Due Date w/Dr's Note
___ Use of Calculator on Exams
___ CCTV or Enlarged Text for Exams
___ Priority Seating in Classroom
___ Use of Tape Recorder in Class
___ Professors' slides and notes when available
___ Use of Computer with Spell Check
___ Use of Computer with Grammar Check
___ Use of Formula/Note Cards
___ Other_____

_____