UNIVERSITY of WISCONSIN
GREEN BAY

Student Accessibility Services

VERIFICATION OF ATTENTIONAL DEFICIT/HYPERACTIVITY DISORDER

Student Accessibility Services provides services to students with diagnosed Attention Deficit/Hyperactivity Disorder (ADHD). To determine eligibility for services, this office requires **current comprehensive documentation** of ADHD from a qualified diagnosing **physician, psychologist, psychiatrist or other licensed medical/mental health professional currently treating the student.**

The provider(s) should attach any reports that provide additional related information (e.g. psycho-educational testing, neuropsychological test result, etc.) *If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted as documentation instead of this form.*

Please Print Legibly

Student Name: _____

Date Completed: _____/_____/_____ Student's Date of Birth _____/_____/_____

1. DSM-5 diagnosis:

   ☐ Predominantly Inattentive
   ☐ Predominantly Hyperactive-Impulsive
   ☐ Combined type
   ☐ Not otherwise specified: _____

2. Date of diagnosis: _____/_____/_____

   First contact with student _____/_____/_____ Last contact with student: _____/_____/_____

3. What is the severity of the disability? Please check one:

   ☐Mild ☐Moderate ☐Severe

   Explain Severity: _____

   _____

4. List medication(s) that the student is currently prescribed including, dosage, frequency of use, the adverse side effects, the effectiveness of the medication and other medications tried.

   _____

   _____

5. Please check all ADHD symptoms listed in the DSM-5 that currently exhibits:

☐ **Inattention:**
- ☐ often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities
- ☐ often has difficulty sustaining attention in tasks or play activities
- ☐ often does not seem to listen when spoken to directly
- ☐ often does not follow through on instructions and details to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
- ☐ often has difficulty organizing tasks and activities
- ☐ often avoids, dislikes, or is reluctant to engage in tasks (such as schoolwork or homework) that require sustained mental effort
- ☐ often loses things necessary for task for activities (e.g. school assignments, pencils, books, etc.)
- ☐ often easily distracted by extraneous stimuli
- ☐ often forgetful in daily activities

☐ **Hyperactivity:**
- ☐ often fidgets with hands or feet or squirms in seat
- ☐ often leaves (or greatly feels the need to leave) seat in classroom or in other situations in which remaining seated is expected
- ☐ often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
- ☐ often has difficulty playing or engaging in leisure activities that are more sedate
- ☐ often "on the go" or often acts as if "driven by a motor"
- ☐ often talks excessively

☐ **Impulsivity:**
- ☐ often blurts out answers before questions have been completed
- ☐ often has difficulty awaiting turn
- ☐ often interrupts or intrudes on others (e.g. butts into conversations or games)

6. Please list and describe the major life activities/functional limitations that are significantly impacted by the disability and degree of severity.

_____

_____

_____

7. Student's History:
   a. AD/HD History:
      Provide evidence of inattention and/or hyperactivity during childhood in more than one setting and presence of symptoms prior to age twelve.

      _____

      _____

      _____

b. Pharmacological History:
Provide relevant pharmacological history, including an explanation of the extent to which the medication prescribed to treat AD/HD has mitigated the symptoms of the disorder in the past.

_____

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_____

8. State specific recommendations regarding academic accommodations for this student, and the rationale as to why these accommodations/services are warranted based upon the student's functional limitation. Indicate why the accommodations are necessary.

_____

_____

_____

9. If current treatments (e.g. medications, counseling, etc.) are successful, state the reasons why the above academic adjustments/accommodations/services are necessary. Please be specific.

_____

_____

_____

10. If any co-morbid conditions exist, please describe.

_____

_____

Provider Information

Name:	**Date:**
Medical Specialty:	**License #:**
Address:	
Email:	**Phone:**
Clinician's Signature:	**Printed Name:**

Please mail or fax this completed form and any additional information to:

Student Accessibility Service
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