



Student Accessibility Services

VERIFICATION OF AUTISM SPECTRUM DISORDERS

Student Accessibility Services provides services to students with Autism Spectrum Disorders. To determine eligibility for services, this office requires **current comprehensive documentation** of this disorder from the diagnosing **psychiatrist, psychologist, neuropsychologist or other licensed mental health professional currently treating the student.**

Please Print Legibly

Student Name: _____

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

1. DSM 5 Diagnosis: _____

2. Date of diagnosis: ____/____/____

First contact with student ____/____/____ Last contact with student: ____/____/____

3. In addition to DSM-5 criteria, how did you arrive at your diagnosis?

- Structured or unstructured clinical interview with the student
- Interviews with other persons
- Behavioral observations
- Developmental history
- Educational history
- Medical history
- Neuropsychological testing (dates of testing) _____

Please attach diagnostic report of testing

- Psychoeducational testing (dates of testing) _____
- Standardized or non-standardized rating scales
- Other (Please specify)

4. What is the severity of the condition? Please check one:

- Mild Moderate Severe

Explain Severity: _____

5. Please list the major life activities/functional limitations, both physical and academic, which are impacted by the disability and the degree of severity (mild, moderate or severe). **(Failure to identify major life activities impacted by disability will result in no accommodations approved)**

6. Please describe your assessment procedures and evaluation instruments providing both quantitative and qualitative information about the student's abilities.

7. Is this student currently receiving therapy or counseling? Yes No

8. What medication(s) is the student currently taking? How effective is the medication? How might side effects, if any, affect the student's academic performance?

9. Describe any situation or environmental conditions that might lead to an exacerbation of the condition.

10. State specific recommendations regarding academic accommodations for this student, and a rationale as to why these accommodations/services are warranted based upon the student's functional limitations. Indicate why the accommodations are necessary (e.g. if a note taker is suggested, state reasons for this request related to the student's diagnosis).



11. Are there any other considerations that should be taken into account when determining appropriate accommodations and interventions for the student, e.g. housing, transportation, assistive technology, etc.?

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

Provider Information

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

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

Student Accessibility Services
UW-Green Bay
2420 Nicolet Drive, SS 1700
Green Bay, WI 54311

920-465-2841
FAX 920-465-2191
EMAIL: SAS@UWGB.EDU