UNIVERSITY of WISCONSIN GREEN BAY

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
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