Disability Services Office

VERIFICATION OF AUTISM SPECTRUM DISORDERS

The Disability Services Office 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

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Specialty:</td>
<td>License #:</td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td>Email:</td>
</tr>
<tr>
<td>Clinician’s Signature:</td>
<td>Printed Name:</td>
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</tbody>
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Please mail or fax this completed form and any additional information to:

Disability Services Office  
UW-Green Bay  
2420 Nicolet Drive, SS 1700  
Green Bay, WI  54311  
920-465-2841  
FAX 920-465-2191  
EMAIL: DIS@UWGB.EDU