Services for Students with Disabilities
Verification Form for Students with Attention-Deficit/Hyperactivity Disorder and Psychological Disabilities

This form is intended to assist in meeting our documentation requirements for these disabilities. However, if not thoroughly completed, it may not be sufficient as the sole form of documentation provided. Please refer to the “Guidelines for Documenting Psychological Disabilities” or “Guidelines for Documenting Attention-Deficit/Hyperactivity Disorder” for comprehensive documentation requirements and additional information. To ensure the provision of reasonable and appropriate accommodations, students requesting services must provide current (within the last 12 months for Psychological and 3 years for ADHD) documentation of the disability. This documentation should provide information regarding the onset, longevity and severity of symptoms, as well as the specifics describing how it has interfered with educational achievement. Please include a copy (including test scores) of any relevant psychoeducational or neuropsychological reports. To standardize our gathering of information, it is recommended that you complete the following questions, even if the material has already been included in your full evaluation. All information will be kept confidential. Please feel free to contact SSD at (512) 471-6259 with questions.

The information below is to be completed and signed by the student.

I request and authorize The University of Texas at Austin University Health Services (UHS), Counseling & Mental Health Center (CMHC), Services for Students with Disabilities and/or my off-campus provider (name)_________________________________________________________ to release, fax, mail or discuss with each other information related to my registering with Services for Students with Disabilities (SSD).

__________________________________________
Student Name

EID

__________________________________________
Student Signature

Date

Email Address: _____________________________ Phone Number: _________________________

If the information above is left blank or is incomplete it may delay or prevent SSD from contacting the student to verify receipt of the documentation and provide next steps for completing the registration process.
The information below is to be completed and signed by the Provider.

1. Please list all DSM-5 or ICD Diagnoses (name and at least one code):

Diagnoses:

   1. _____________________________________________    __________   __________
   2. _____________________________________________    __________   __________
   3. _____________________________________________    __________   __________
   4. _____________________________________________    __________   __________
   5. _____________________________________________    __________   __________

DSM-5 diagnosis name(s)    DSM-5 code(s)    ICD-10 code(s)

   a. Date diagnosed: __________/__________/__________
   b. Date of your last clinical contact with student: __________/__________/__________

2. Evaluation

   a. How did you arrive at this diagnosis? Please check all relevant items below, adding brief notes that you think might be helpful to us as we determine eligibility for accommodations.

      o Structured or unstructured interviews with student.
      o Interviews with other persons (i.e. parent, teacher, therapist).
      o Behavioral observations.
      o Neuropsychological testing. Attach documentation.
      o Psychoeducational testing. Attach documentation.
      o Other (Please specify). _____________________________________________________________

   b. Current treatment being received by student:

      o Medication management:
         Current medications: _____________________________________________________________
      o Outpatient therapy:
         Frequency: _________________________________________________________________
      o Group therapy:
         Frequency: _________________________________________________________________
      o Other (please describe):
         _________________________________________________________________
c. Approximate onset of diagnosis:
   - Child- approximate age: __________
   - Adolescent- approximate age: __________
   - Adult- approximate age: __________
   - Unknown

Severity of symptoms
   - Mild
   - Moderate
   - Severe

Prognosis of disorder:
   - good
   - fair
   - poor

Please explain: __________________________________________________________

_________________________________________________________________

3. Functional Limitations: Should be determined WITHOUT consideration of mitigating measures (i.e. medication, etc.). If condition is episodic in nature, level of functioning should be assessed based on active phase of symptoms.

   a. Does this condition significantly limit one or more of the following major life activities?

<table>
<thead>
<tr>
<th>Activity</th>
<th>No Impact</th>
<th>Moderate Impact</th>
<th>Substantial Impact</th>
<th>Don't Know</th>
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</thead>
<tbody>
<tr>
<td>Communicating</td>
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<td>Concentrating</td>
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<td>Hearing</td>
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<td>Learning</td>
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<td>Manual Tasks</td>
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<td>Reading</td>
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<td>Seeing</td>
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<td>Other:</td>
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b. Please check the **functional limitations or behavioral manifestations** for this student:

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<th></th>
<th>Not an Issue</th>
<th>Moderate Issue</th>
<th>Substantial Issue</th>
<th>Don't Know</th>
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<tbody>
<tr>
<td>Cognitive Processing</td>
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<td>Memory</td>
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<td>Processing Speed</td>
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<tr>
<td>Meeting Deadlines</td>
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<td>Attending class</td>
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<td>Organization</td>
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<td>Reasoning</td>
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<td>Stress</td>
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<td>Appetite</td>
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<td>Other:</td>
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<td>Other:</td>
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c. Please describe in detail any functional limitations that fall into the substantial range.

__________________________________________________________________________________
__________________________________________________________________________________

d. Special considerations, e.g. medication side effects: ______________________________
__________________________________________________________________________________
__________________________________________________________________________________

**COURSE LOAD REDUCTION**: Is the student’s condition such that it may require them to drop a course and/or take fewer than what is considered a full-time course load?

- Yes
- No
- I don’t know

If YES please explain: __________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
4. **Accommodations**

   a. Please mark whether student has utilized accommodations in the past.
      
      - Yes - Please describe: ______________________________________________________
      - No
      - Don't Know

   b. (Optional) Recommended educational accommodations:
      ______________________________________________________
      ______________________________________________________
      ______________________________________________________

   c. (Optional) Please provide any additional information you feel will be useful in determining the nature and severity of the student’s disability, and any additional recommendations that may assist in determining appropriate accommodations and interventions:
      ______________________________________________________
      ______________________________________________________
      ______________________________________________________

*Thank you for your help in providing this information so that we may begin services as soon as possible. Please complete the provider information below. This form should be signed and returned via fax or mail to the SSD office at the address shown at the end of this document. All documentation submitted to SSD is considered confidential.*

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**Provider Information**

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

Signature: __________________________ Date: __________________________
Print Name and Title: __________________________ __________________________
State of License: __________________________ License Number: __________________________
Address __________________________
Street or P.O. Box __________________________ City __________________________ State _______ Zip
Phone: __________________________ Fax: __________________________

*Please return this form to:*
The University of Texas at Austin
Division of Diversity and Community Engagement
Services for Students with Disabilities
100 W. Dean Keeton St. Stop A4100
Austin, TX  78712-1093
Phone: (512) 471-6259
Fax: (512) 475-7730
VP: (512) 410-6644

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**Attach Provider Business Card Here**