DIVISION OF DIVERSITY AND COMMUNITY ENGAGEMENT

THE UNIVERSITY OF TEXAS AT AUSTIN

Services for Students with Disabilities •100 W. Dean Keeton St. Stop A4100 • Austin, TX 78712-1093
http://diversity.utexas.edu/disability/ (512) 471-6259 • FAX (512) 475-7730 • VP (512) 410-6644

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 (<u>name and at least one code</u>):

Diagnoses:

	DSM-5 diagnosis name(s)	DSM-5 code(s)	ICD-10 code(s)
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

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**?

	No Impact	Moderate Impact	Substantial Impact	Don't Know
Communicating				
Concentrating				
Hearing				
Learning				
Manual Tasks				
Reading				
Seeing				
Thinking				
Walking				
Working				
Other:				

b. Please check the **functional limitations or behavioral manifestations** for this student:

	Not an Issue	Moderate Issue	Substantial Issue	Don't Know
Cognitive Processing				
Memory				
Processing Speed				
Meeting Deadlines				
Attending class				
Organization				
Reasoning				
Stress				
Sleep				
Appetite				
Other:				
Other:				

c. Please describe in detail any functional limitations that fall into the substantial range.

_____

_____

d. Special considerations, e.g. medication side effects: _____

_____

_____

e. ***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?

- o Yes
- o No
- o I don't know

If YES please explain:_____

_____

_____

4. Accommodations

a. Please mark whether student has utilized accommodations in the past.

- o Yes- Please describe:_____
- o No
- o 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.

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
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Austin, TX 78712-1093
Phone: (512) 471-6259
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Attach Provider Business Card Here