**Documentation requirements for AD/HD**

Disability Services provides academic accommodations and services to students with AD/HD. Students seeking accommodations must provide comprehensive and relevant documentation of their disability so that the office of Disability Services can determine the student’s eligibility for services and appropriate academic accommodations.

**Documentation should include:**

1) A completed disability verification form (pages 2-4 of this document).

OR

1) A relevant and comprehensive adult normed psychoeducational or neuropsychological evaluation. To include: clear statement of disability including diagnosis, test scores, clinical assessment of procedures and evaluators narrative.

**All documentation is considered confidential and can be mailed or faxed to:**

Disability Services  
Assumption College  
500 Salisbury Street  
Worcester, MA 01609  
Fax: (508)767-7139  
Phone: (508)767-7500
Disability Verification Form – AD/HD (to be completed by appropriate practitioner)

This form is intended to assist your patient in meeting the documentation requirements for requesting academic accommodations on the basis of AD/HD at Assumption College. Please fill out all of the questions on the form below.

All information is considered confidential. Please feel free to contact Disability Services with any questions.

Student/Patient Name: __________________________________________________________

1. Please list all DSM-IV or ICD Diagnoses (text and code):
   AXIS I:
   AXIS II:
   AXIS III:
   AXIS IV:
   AXIS V
   Severity of disorder (current GAF Score) _____________________________
   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.
      - Structured or unstructured interviews with student
      - Interviews with other persons (i.e. parent, teacher, therapist)
      - Behavioral observations
      - Neuropsychological testing. Attach documentation
      - Psychoeducational testing. Attach documentation
      - Other (Please specify) ______________________________________________________
   b. Date of last evaluation _______________________________________________________
   c. Corroboration of history of childhood onset? Y ☐ N ☐
      By whom? _________________________________________________________________

3. Functional Limitations Y ☐ N ☐ If yes, please describe: ________________________________________________________________
   a. Please describe in detail any functional limitations that fall into the significant range.
b. Please list current medications and treatment history.

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

c. Special considerations, e.g. medication side effects:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

4. Coexisting Conditions
Please provide details about any coexisting psychiatric or medical conditions.

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

5. Past Accommodations
Please mark whether student has utilized accommodations in the past. Y □  N □
Please describe:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

6. Suggested Accommodations
Please list the specific academic accommodations you suggest based on your assessment of the student’s clinical and academic history and diagnosis.

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

7. (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 recommendation 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 to the office of Disability Services at Assumption College, 500 Salisbury Street, Worcester, MA 01609 or by fax to (508)767-7139.
PL EASE NOTE:

To provide documentation of AD/HD, the evaluation must have been conducted or formally supervised and cosigned by a physician, licensed clinical psychologist, or one who holds a doctorate in neuropsychology, clinical psychology, educational psychology, or other appropriate specialty. Such evaluators are required to have been 1) trained in psychiatric, psychological, neuropsychological and/or psychoeducational assessment; and 2) have at least three years experience in the evaluation of students with learning disabilities, ADHD/ADD, or psychiatric disabilities.

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: ______________________________________________________________________

____________________________________________________________________________

Phone: ______________________ Fax: ______________________________

Please return this signed disability verification form:

Disability Services
Assumption College
500 Salisbury Street
Worcester, MA 01609
Fax: (508)767-7139
Phone: (508)767-7500