**Documentation requirements for AD/HD**

Student Accessibility 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 Student Accessibility 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:**

Student Accessibility 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 Student Accessibility 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 Student Accessibility Services at Assumption College, 500 Salisbury Street, Worcester, MA 01609 or by fax to (508)767-7139.
**PLEASE 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:**

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