Autism Spectrum Disorder Documentation Instructions and Form  
Updated March 2024

Student Instructions and Information:

- Students must submit current documentation to the Office of Accessibility and Testing Services.
  - Current documentation is defined as:
    - Documentation that reflects data collected within three years at the time of request for services.
    - It is at the Accessibility and Testing specialist's discretion to make appropriate exceptions to this policy and/or to request a reevaluation and more recent documentation in order to establish the most appropriate accommodations.
- A qualified provider (medical doctor, psychologist, or psychiatrist) must provide the documentation.
- In place of this form, a letter may be provided including all of the requested information. Any letters must be on letterhead from the provider’s practice. Any documentation must include the provider’s signature and credentials.
- Students are encouraged to provide documentation prior to the intake meeting if at all possible. It is during the intake meeting that appropriate accommodations, and the process for using the accommodations, will be discussed.
- For timely review of application, documentation must be submitted by the student requesting services via our secure portal, AIM located on our website. If you have any questions regarding this process, please email to accessibility-services@westga.edu.

To be Completed by Student:

Name (Last, First, Middle): ________________________________________________________________

Date of Birth: ___________________________ UWG ID Number: 917___________________________

Cell Phone: ________________________________ Alternate Phone: _____________________________

Home Address: _____________________________________________________________________________

__________________________________________________________________________________________

Email Address: _____________________________________________________________________________

Status (Check One): _____Current Student  _____ Transfer Student  _____ Prospective Student
To be Completed by Provider:

The Office of Accessibility and Testing Services establishes academic and/or housing accommodations for students with a documented disability. The Americans with Disabilities Act (ADA) defines a disability as a physical or mental impairment that substantially limits one or more major life activities. The University System of Georgia Board of Regents (USGBOR) requires current and comprehensive documentation for any diagnosis of a disability in order for disability services providers to determine appropriate accommodations and services. Please see Appendices D-H of the USGBOR Academic and Student Affairs Handbook for more information.

Please check all of the following DSM-5 diagnostic criteria as appropriate to describe current symptoms. Attach standardized assessments (e.g. Autism Diagnostic Observation System, Autism Diagnostic Interview-Revised, Social Communications Questionnaire) as appropriate.

____ Persistent deficits in social communication and social interactions across multiple contexts, such as deficits in:
    ____ Social-emotional reciprocity
    ____ Nonverbal communicative behaviors used for social interaction
    ____ Developing, maintaining, and understanding relationships

____ Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following:
    ____ Stereotyped or repetitive motor movements, use of objects, or speech
    ____ Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal/nonverbal behavior
    ____ Highly restricted, fixated interests that are abnormal in intensity or focus
    ____ Hyper- or hypo reactivity to sensory input or unusual interests in sensory aspects of the environment

Please indicate the severity level of the disorder as appropriate.
    ____ Level 1: Requiring support
    ____ Level 2: Requiring substantial support
    ____ Level 3: Requiring very substantial support

Please describe the history of the disorder, specifically the above listed symptoms present in early childhood.

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Please check all of the following as appropriate to describe the patient’s functional limitations.

____ Poor concentration
____ Distracted by internal stimuli
Disorganized
Difficulty letting go of ideas, accepting alternate ideas
Difficulty communicating with faculty/staff and/or other students
Struggles with making friends and fitting in with peers
Difficulty taking responsibility for own learning and completing tasks according to timetables
Trouble living with others, need for quiet and solitude in order to work and study
Problems interacting with others in seminars or groups
Difficulty speaking in public
High levels of anxiety and vulnerability to stress
Poor time management
Problems in learning by observation
Difficulties with ambiguous instructions
Other

Other

Other

Please provide any additional information/context as appropriate concerning the functional limitations.

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Please provide any recommendations to address the indicated functional limitations.

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Please attach any psychological and/or educational reports that support the diagnosis and complete the following information:

PLEASE NOTE: Assessment of broad cognitive ability using standardized assessment measures with age appropriate norms (e.g. WAIS-IV, DAS, RIAS, C-TONI) is required.

ATTENTION PROVIDER: By signing below you are verifying that the individual has been diagnosed with Autism Spectrum Disorder (DSM-5 Code F84.0). Specify if:

_____ With accompanying intellectual impairment
_____ With accompanying language impairment
_____ Associated with a known medical or genetic or environmental factor

Provider Name:______________________________________________________________

Title:_____________________________________________________________________

License #:__________________________________________________________________

Practice Name and Address:___________________________________________________

____________________________________________________________________________

Phone:________________________________________ Fax:___________________________

Email:_____________________________________________________________________

Provider Signature (REQUIRED):______________________________________________

Date of Signature:_________________________________________________________________