Autism Spectrum Disorder Documentation Instructions and Form

Updated December, 2015

Student Instructions and Information:

- Students must submit **current** documentation to Accessibility 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 Services counselor'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 asked 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.
- Documentation can be submitted in person or by mail to the UWG Counseling Center, 123 Row Hall, Carrollton, GA 30118, by fax to 678-839-6429, or by email to counseling@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 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:_____