Accommodation Services Office

DOCUMENTATION OF AUTISM SPECTRUM DISORDER

The Accommodation Services Office provides services to students with a diagnosed Autism Spectrum Disorder. To determine eligibility for services, this office requires **current comprehensive documentation** of this disorder from a qualified diagnosing **psychologist, psychiatrist, neurologist or other licensed mental health professional currently treating the student.**

The provider(s) should attach any reports that provide additional related information (e.g. psycho-educational testing, neuropsychological test results, etc). ***If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted as documentation instead of this form.***

Please Print Legibly

Student Name: ____

Date Completed: _____/______/_______ Student's Date of Birth _____/_____/________

1. DSM-5 diagnosis: ____

2. Date of diagnosis: ______/______/______

   First contact with student: _____/_____/______ Last contact with student: _____/_____/______

3. In addition to DSM 5 criteria, how did you arrive at your diagnosis?

   ☐ Structured or unstructured clinical interviews with the individual
   ☐ Interviews with other individuals
   ☐ Behavioral observations
   ☐ Developmental history
   ☐ Educational history
   ☐ Medical history
   ☐ Neuropsychological testing – Date: ______________________________
   Please attach diagnostic report
   ☐ Psycho-educational testing – Date: ______________________________
   Please attach diagnostic report
   ☐ Standardized or non-standardized rating scales
   ☐ Other (please specify): ____

4. What is the severity of the disability? Please check one:

   ☐ Mild ☐ Moderate ☐ Severe

   Explain Severity: ____

   ____

5. Please list and describe the major life activities/functional limitations, both physical and academic, which are significantly impacted by the disability and degree of severity. ***Please note, if no major life activities are significantly impacted, no accommodations will be approved.***

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6. Please describe your assessment procedures and evaluation instruments and results (you may skip if diagnostic reports are attached).

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7. List current medications that may impact the student in the educational setting, and what impact they may have.

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8. Describe any situations or environmental conditions that might lead to an exacerbation of the condition.

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9. State specific recommendations regarding academic accommodations for this student, and the rationale as to why these accommodations/services are warranted based upon the student's functional limitations. Indicate why the accommodations are necessary (e.g., if a note taker is suggested, state reasons for this request related to the student's diagnosis).

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10. If any co-morbid conditions exist, please describe.

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Provider Information

Name (Please Print):	
Medical Specialty:	License #:
Address:	
Phone:	Email:
Signature:	Date:

Please mail or fax this completed form and any additional information to:

Accommodation Services Office
Lakeshore Technical College
1290 North Avenue
Cleveland, WI 53015

Phone: (920) 693-1222 or (920) 693-1274
Fax: (920) 693-1827