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 <u>currently</u> 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: _____

   _____

Accommodation Services
Phone: 920.693.1120 (Nicole) | 920.693.1274 (Christi)| 711 (Wisconsin Relay)
Email: nicole.yang@gotoltc.edu |christi.leonhard@gotoltc.edu
Fax: 920.693.1827 | Web: www.gotoltc.edu

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.

_____

_____

_____

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

_____

_____

_____

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).

_____

_____

_____

_____

_____

_____

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

_____

_____

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

Fax: (920) 693-1827