

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: \_\_\_\_\_

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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

<b>Name (Please Print):</b>	
<b>Medical Specialty:</b>	<b>License #:</b>
<b>Address:</b>	
<b>Phone:</b>	<b>Email:</b>
<b>Signature:</b>	<b>Date:</b>

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

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

Fax: (920) 646.7262