Disabilities Services
Verification Form for Students with Autism Spectrum Disorders

This form is intended to assist in meeting our documentation requirements for these disabilities. However, if not thoroughly completed, it may not be sufficient as the sole form of documentation provided. To ensure the provision of reasonable and appropriate accommodations, students requesting services must provide current (within the last 3 years) documentation of the disability. This documentation should provide information regarding the onset, longevity and severity of symptoms, as well as the specifics describing how it has interfered with educational achievement. Please include a copy (including test scores) of any relevant psychoeducational or neuropsychological reports. To standardize our gathering of information, it is recommended that you complete the following questions, even if the material has already been included in your full evaluation. All information will be kept confidential. Please feel free to contact Disabilities Services (DS) at (405) 789-7661 Ext: 3424 with questions.

The information below is to be completed and signed by the student.

I request and authorize Southwestern Christian University at Bethany, OK, and Disabilities Services and/or my off-campus provider
(name) ____________________________________________________________ to release, fax, mail or discuss with each other information related to my registering with Disabilities Services (DS).

____________________________________________________________________
Student Name

____________________________________________________________________
Student Signature

____________________________________________________________________
Email Address: __________________________________________ Phone Number: _______________________

If the information above is left blank or is incomplete it may delay or prevent DS from contacting the student to verify receipt of the documentation and provide next steps for completing the registration process.
The information below is to be completed and signed by the Provider.

1. Please list all DSM-5 or ICD Diagnoses (name and at least one code):

Diagnoses:

1. ____________________________________  __________  __________

2. ____________________________________  __________  __________

3. ____________________________________  __________  __________

4. ____________________________________  __________  __________

5. ____________________________________  DSM-5 diagnosis name(s)  DSM-5 code(s)  ICD-10 code(s)

a. Date diagnosed: __________/__________/__________

b. Date of your last clinical contact with student: __________/__________/__________

2. Evaluation

a. How did you arrive at this diagnosis? Please check all relevant items below, adding brief notes that you think might be helpful to us as we determine eligibility for accommodations.

- Structured or unstructured interviews with student.
- Interviews with other persons (i.e. parent, teacher,
- Behavioral
- Neuropsychological testing. Attach documentation.
- Other (Please __________)

b. Current treatment being received by student:

- Medication
  Current medications: __________

- Outpatient
  Frequency: __________

- Group
  Frequency: __________

- Other (please __________

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c. Approximate onset of diagnosis:
   - Child - approximate ____________
   - Adolescent - approximate ____________
   - Adult - approximate ____________

Severity of symptoms
   -
   -

Prognosis of disorder:
   -
   -

Please explain: ____________________________________________
__________________________________________________________________________

3. Functional Limitations: Should be determined WITHOUT consideration of mitigating measures (i.e. medication, etc.). If condition is episodic in nature, level of functioning should be assessed based on active phase of symptoms.

a. Does this condition significantly limit one or more of the following major life activities?

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<th></th>
<th>No Impact</th>
<th>Moderate Impact</th>
<th>Substantial Impact</th>
<th>Don't Know</th>
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<tbody>
<tr>
<td>Communicating</td>
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<td>Concentrating</td>
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<td>Hearing</td>
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<td>Learning</td>
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<td>Manual Tasks</td>
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<td>Reading</td>
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<td>Other:</td>
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b. Please check the **functional limitations or behavioral manifestations** for this student:

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<th>Not an Issue</th>
<th>Moderate Issue</th>
<th>Substantial Issue</th>
<th>Don't Know</th>
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<td>Understanding Nonverbal</td>
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<td>Behaviors</td>
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<td>Peer Relationships /</td>
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<td>Emotional Expression</td>
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<td>Cognitive Processing</td>
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<td>Memory</td>
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<td>Processing Speed</td>
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<tr>
<td>Meeting Deadlines</td>
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<td>Attending class</td>
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<td>Organization</td>
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<td>Reasoning</td>
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<td>Stress</td>
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<td>Appetite</td>
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<td>Other:</td>
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c. Please describe in detail any functional limitations that fall into the substantial range.

________________________________________________________________________________________

________________________________________________________________________________________

d. Special considerations, e.g. medication side effects: __________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

e. **COURSE LOAD REDUCTION**: Is the student's condition such that it may require them to drop a course and/or take fewer than what is considered a full-time course load?

  ○
  ○
  ○ I don’t

If YES please explain: __________________________________________________________________________

________________________________________________________________________________________
4. Accommodations

a. Please mark whether student has utilized accommodations in the past.

○ Yes - Please

○

○ Don't

b. (Optional) Recommended educational accommodations:

________________________________________________________________________

________________________________________________________________________

c. (Optional) Please provide any additional information you feel will be useful in determining the nature and severity of the student’s disability, and any additional recommendations that may assist in determining appropriate accommodations and interventions:

________________________________________________________________________

________________________________________________________________________

Thank you for your help in providing this information so that we may begin services as soon as possible. Please complete the provider information below. This form should be signed and returned via fax or mail to the DS office at the address shown at the end of this document. All documentation submitted to DS is considered confidential.

Provider Information

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

Signature: ___________________________ Date: ___________________________

Print Name and Title: ___________________________

State of License: ___________________________ License Number: ___________________________

Address: ___________________________

Street or P.O. Box: ___________________________ City: ___________________________ State: ___________________________ Zip: ___________________________

Phone: ___________________________ Fax: ___________________________

Please return this form to:
Southwestern Christian University at Bethany, OK
Disabilities Service
7210 NW 39th Expy
Bethany, OK 73008-3637
Phone: (405) 789-7661
Fax: (405) 495-0078
VP: (405) 789-7661 Ext: 3424

Attach Provider Business Card Here