SOUTHWESTERN CHRISTIAN UNIVERISTY AT BETHANY, OK

Disabilities Services •7210 NW 39th Expy • Bethany, OK 73008-3637
disabilites.services@swcu (512) 471-6259 • FAX (512) 475-7730 • VP (512) 410-6644

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 EID

_____

Student Signature Date

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 <u>(name and at least one code):</u>

Diagnoses:

	DSM-5 diagnosis name(s)	DSM-5 code(s)	ICD-10 code(s)
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

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.

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

b. Current treatment being received by student:

- o Medication

  Current medications: _____
- o Outpatient

  Frequency: _____
- o Group

  Frequency: _____
- o Other (please

  _____

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 off unctioning should be assessed based on active phase of symptoms.*

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

	No Impact	Moderate Impact	Substantial Impact	Don't Know
Communicating				
Concentrating				
Hearing				
Learning				
Manual Tasks				
Reading				
Seeing				
Thinking				
Walking				
Working				
Other:				

b. Please check the **functional limitations or behavioral manifestations** for this student:

	Not an Issue	Moderate Issue	Substantial Issue	Don't Know
Understanding Nonverbal Behaviors				
Peer Relationships / Emotional Expression				
Cognitive Processing				
Memory				
Processing Speed				
Meeting Deadlines				
Attending class				
Organization				
Reasoning				
Stress				
Sleep				
Appetite				
Other:				

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?

- o
- o
- o I don't

If YES please explain: _____

_____

4. Accommodations

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

- o Yes- Please _____
- o
- o 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