UNIVERSITY OF DALLAS

Student Disability Services ♦ ***Academic Success Office*** ♦ Haggar 253
1845 East Northgate Drive ♦ Irving, Texas 75062 ♦ www.udallas.edu/academic-success
Phone (972) 721-5056 ♦ Facsimile (972) 265-5712 ♦ Email ada@udallas.edu

Student Disability 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. Please refer to the "Guidelines for Documenting Autism Spectrum Disorders" for comprehensive documentation requirements and additional information. 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 the ADA/Section 504 Coordinator at (972) 721-5056 with questions.

The information below and the release of information on the second page are to be completed and signed by the student.

_____

Student Name UD ID

_____

Student Signature Date

Email Address: _____

Phone Number: _____

If the information above is left blank or is incomplete it may delay or prevent SDS from contacting the student to verify receipt of the documentation and provide next steps for completing the registration process.

CONSENT AND AUTHORIZATION TO RELEASE INFORMATION TO STUDENT DISABILITY SERVICES

Pursuant to Federal and State law concerning my right to confidentiality and privileged communication, I, _____, hereby authorize:

_____
Person or Organization

_____
Address

_____
City, State, Zip Code

_____ _____
Phone Number Fax Number

To release the following information:

_____ Information Requested on this Verification Form

_____ Diagnosis

_____ Psych-Educational/Neuropsychological Evaluations

_____ Psychological Evaluation

_____ History of previously used accommodations

_____ Other: _____

Documentation needed to request academic, dietary, and/or housing accommodations at post-secondary institution.

The information is to be provided to:

Student Disability Services, Braniff
132 University of Dallas
1845 East Northgate Drive
Irving, Texas 75062
Phone: (972) 721-5056
Fax: (972) 265-5712
Email: ada@udallas.edu

Purpose of disclosure:

I understand this authorization for confidential information applies only to the individual named above and only for a period of 180 days and does not permit the release of information concerning me to any other individual. In addition, I understand I may revoke this consent to release information at any time, but recognize that any release made between the time I authorized it and then revoked it shall not constitute a breach of my right to confidentiality.

A photocopy or fax of this authorization shall be considered as effective and valid as the original.

Student Signature: _____ Date: _____

UD Student ID: _____ Date of Birth: _____

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:

   1. _____ _____ _____
   2. _____ _____ _____
   3. _____ _____ _____
   4. _____ _____ _____
   5. _____ _____ _____

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

   a. Approximate onset of symptoms

   - ○ Child-approximate age: _____
   - ○ Adolescent-approximate age: _____
   - ○ Adult-approximate age: _____
   - ○ Unknown

   b. Date of current diagnoses: _____ /_____ /_____

   c. 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, therapist).
   - ○ Behavioral observations.
   - ○ Neuropsychological testing. Attach documentation.
   - ○ Psychoeducational testing. Attach documentation.
   - ○ Other (Please specify). _____

   b. Current treatment being received by student:

   - ○ Medication management:
     Current medications: _____
   - ○ Outpatient therapy:
     Frequency: _____
   - ○ Group therapy:
     Frequency: _____

○ Other (please describe):

_____

c. Severity of symptoms

○ Mild

○ Moderate

○ Severe

d. Prognosis of disorder:

○ Good

○ Fair

○ Poor

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?

	No Impact	Moderate Issue	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:				
Other:				

c. Please describe in detail any functional limitations that fall into the substantial range.

_____

_____

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

_____

_____

4. **Accommodations**

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

- ○ Yes- Please describe:

  _____
- ○ No
- ○ Don't Know

b. Recommended accommodations. Please provide a rationale for each accommodation. In the absence of a rationale, Student Disability Services may be unable to recommend the proposed accommodation:

_____

_____

_____

_____

c. 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:

_____

_____

d. **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?

- ○ Yes
- ○ No
- ○ I don't know

If YES please explain: _____

_____

_____

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 SDS office at the address shown at the end of this document. ***All documentation submitted to SDS 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:

University of Dallas
Student Disability Services
Academic Success Office 1845 East
Northgate Drive Irving, Texas 75062 Phone:
(972) 721-5056 Facsimile: (972) 265-5712

Attach Provider Business Card Here

[Adapted from https://diversity.utexas.edu/disability/wp-content/uploads/2018/07/Medical.VerForm-2015-Updated.pdf, with permission from ITS, The University of Texas at Austin, Austin, Texas 78712-1110.]