Verification of Attention Deficit/Hyperactivity Disorder

The student named below has applied for services from the Special Needs Department at Gateway Technical College. In order to provide reasonable and appropriate services, current and comprehensive information regarding the functional impact of the disability is required. This form is intended to provide the Special Needs staff with sufficient information so that eligibility for services and appropriate accommodations can be determined. The information you provide is confidential and will not become part of the student's education record. In addition to the requested information, please attach any additional information you deem appropriate. Thank you for your assistance.

1. Name of student: ____ Date of Birth:___________
2. Date of your last contact with student: ____
3. What is the DSM-IV multi-axial diagnosis for this student?

   Axis I: ____

   Axis II: ____

   Axis III: ____

   Axis IV: ____

   Axis V: ____

4. Please list any medications that have been prescribed for this student:

Medication:	Date Prescribed:
____	_____________________
____	_____________________
____	_____________________

5. What methods or testing instruments did you use to arrive at your diagnosis? Please check all relevant items including brief comments that you think might be helpful to us as we determine appropriate accommodations for this student.
   - ☐ Structured or unstructured clinical interviews with the individual
   - ☐ Interviews with other individuals
   - ☐ Academic history of elementary, secondary, tertiary education
   - ☐ Developmental history
   - ☐ Medical history
   - ☐ Psychological testing. Date(s) of testing? ______________________________
   - ☐ Standardized or non-standardized rating scales
   - ☐ Other (please specify)

     ____

6. Please asses the degree of functional impairment due to AD/HD demonstrated by your patient.

1 = Negligible 2 = Moderate 3 = Substantial 4 = Severe

1)	Time Management	1	2	3	4
2)	Organization Skills (physical and/or cognitive)	1	2	3	4
3)	Concentration	1	2	3	4
4)	Memorization	1	2	3	4
5)	Reading (fluency, comprehension)	1	2	3	4
6)	Quantitative Skills	1	2	3	4
7)	Written Expression	1	2	3	4
8)	Sleeping	1	2	3	4
9)	Social Interactions	1	2	3	4
10)	Information Processing	1	2	3	4
11)	Self-care	1	2	3	4
12)	Other ______________________________	1	2	3	4

7. Please describe functional limitations this student encounters when using medication.

8. If the student is undergoing treatment, please describe how the treatment may affect the student in a post-secondary setting.

9. Is there anything else you would like us to know about this student?

____ __________________________

Signature of Professional Date

____ ___________________________

Medical Professional's Name and Title (printed) License Number

____

Address City State Zip

____ _______________________________________

Telephone Number Fax Number