Office of Student Accessibility and Advocacy
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Verification Form: Autism Spectrum (ASD)

4.30.20

Albright College's Student Accessibility and Advocacy Office (SAA) has established verification forms to assist in obtaining current information from a qualified professional (Medical Physician, Neurologist/ Neuropsychologists, Clinical Psychologist, Licensed Counselor or other relevant provider) regarding a student's condition and symptoms. This form should be filled out by a licensed professional who has been treating this individual for a minimum of 3 months. In order to assist the student, it is important for us to understand the student's symptoms, related medications, their impact on the student, and their need for accommodations. This Verification Form may supplement information that is provided in other reports, including medical reports or secondary school documentation. It is not a replacement for a full evaluation or test scores. Any documentation must meet Albright College's documentation standards for the student's condition.

A summary of the criteria for documenting a disability is listed below. Complete information can be found in the Albright College's Documentation Standards which is provided to the student. If you would like a copy of the standards, please call our office.

- Evidence of a disability as defined by the ADAA
- Documentation is no more than 3 years old except in rare circumstances
- Functional impairment affecting an important life skill and how this effects the student in the college environment
- History relevant to the student's disability, including treatments, assistive devices, or other pertinent information
- A clear link between the recommended accommodation and the student's functional limitations
- Summary and recommendations

Student Information: (Please Print Legibly)

Student's Name	
Date of Birth	

Cell Phone Number	
Local Address	
Home Address	

Provider Section (Please Print Legibly or Type. Illegible documentation will not be processed)

Date of Initial Contact with Student	
Date of Last Contact with Student	
How long have you been treating the student for THIS condition?	
Frequency of appointments with Student relating to THIS condition (e.g. weekly, once a month, etc.)	

Diagnosis

What is the student's *primary* diagnosis?_____
DSM Code _____
Descriptive Features: _____
When was the student diagnosed with this condition? _____ (month) _____ (year)
What is the severity of the impairment? _____ Mild _____ Moderate _____ Severe
Explain how you determined the severity above.

How was this student diagnosed/ what diagnostic tools or tests were utilized? (Please attach these results to this form)

Other diagnosis?_____
DSM Code _____
Descriptive Features: _____
When was the student diagnosed with this condition? _____ (month) _____ (year)
What is the severity of the impairment? _____ Mild _____ Moderate _____ Severe
Explain how you determined the severity above.

How was this student diagnosed/ what diagnostic tools or tests were utilized? (Please attach these results to this form)

Other diagnosis?_____
DSM Code _____
Descriptive Features: _____
When was the student diagnosed with this condition? _____ (month) _____ (year)
What is the severity of the impairment? _____ Mild _____ Moderate _____ Severe
Explain how you determined the severity above.

How was this student diagnosed/ what diagnostic tools or tests were utilized? (Please attach these results to this form)

DSM 5 Codes

Does the student have a history of ASD symptoms? _____ Yes _____ No
Approximately what age did the student exhibit ASD symptoms? _____
At approximately what age was the student diagnosed with ASD? _____

Was an ASD-specific evaluation and/or rating scale used to obtain information about the student's symptoms and functioning?

____ Yes, Evaluation tool used: _____
(Please attach the results to this form)

____ No Please explain below how you reached your conclusion about the ASD diagnosis and treatment

Based on the DSM-5 Severity rating scale, what is the severity of the disorder with regards to social communication?

_____ Level 1 (Requires Support)
_____ Level 2 (Requires Substantial Support)
_____ Level 3 (Requires Very Substantial Support)

Based on the DSM-5 Severity rating scale, what is the severity of the disorder with regards to restricted interests and repetitive behaviors?

_____ Level 1 (Requires Support)
_____ Level 2 (Requires Substantial Support)
_____ Level 3 (Requires Very Substantial Support)

Please provide information regarding the student's current presenting symptoms with regard

Current Symptoms:

to the following:

Social interaction and verbal communication with others	
Non-verbal communication	
Repetitive patterns of behavior	
Inflexible adherence to routines	
Hyper or hypo reactivity to sensory input	

Is there clear evidence that the student's symptoms associated with their diagnosis are interfering with or reducing the quality of at least one of the following within the academic environment? Please explain in the space provided

Academic Functioning	
Social Functioning	

Work Functioning	
Language Functioning	

Intellectual and Academic Abilities:

Please provide information regarding the student's comprehensive intellectual functioning and academic functioning as measured by aptitude and achievement tests. (If you have completed a neuropsychological or psychoeducational report that contains this information, please attach it to this form)

Is this information contained within an evaluation report that will be submitted along with the verification form?

_____ Yes (skip to the section labeled pharmacology)
_____ No (please complete the information below)

Aptitude: Please list the following (attach a separate page if necessary)

- Name of the most current aptitude/ cognitive instrument administered
- The age at the time administered
- The Standard scores for each subtest
- The Percentiles for each subtest

Achievement: Please list the following (attach a separate page if necessary)

- Name of the most current aptitude/ cognitive instrument administered
- The age at the time administered
- The Standard scores for each subtest
- The Percentiles for each subtest

Pharmacology and Side Effects

Is the student taking any prescribed medications for the diagnosis that you are treating the student for, or any other medication which may impact the student's ability to function in the college environment?

Yes No

If yes, please provide the information below for each medication the student is prescribed.

Medication/ Dosage/ Frequency	
Date Prescribed	
Side effects that impact the student's functioning (e.g. concentration, sleep, eating, etc.)	

Medication/ Dosage/ Frequency	
Date Prescribed	
Side effects that impact the student's functioning (e.g. concentration, sleep, eating, etc.)	

Medication/ Dosage/ Frequency	
Date Prescribed	
Side effects that impact the student's functioning (e.g. concentration, sleep, eating, etc.)	

Functional Limitations and Recommended Accommodations

It is important for us to understand how the student's current symptoms cause functional impairments in a college environment. Accommodations are not based on the student's diagnosis or medication, but rather on the limitations to his/ her functioning in the educational environment. Based on your knowledge of the student, please provide information regarding what reasonable academic accommodations and the rationale for each accommodation based on the student's symptoms.

Symptom:	
Explanation as to how this symptom effects the student:	

Recommended Reasonable Accommodation(s)	

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Symptom:	
Explanation as to how this symptom effects the student:	
Recommended Reasonable Accommodation(s)	

Is there any other historical information related to the student's impairment that you feel is necessary to consider? (medical, psychological, developmental, etc.)

Provider's Certifying Information

Professionals rendering assessments, diagnosis and providing recommendations for reasonable accommodations must be relevant and qualified to do so (medical doctor, neurologist/ neuropsychologist, psychologist, licensed counselor, etc.). The provider signing this form must be the same person who answered the questions above and may NOT be related to the student.

Provider's Name	
Credentials	
Office or Business Name	
License Number	
State of Licenser	
Street Address	
Office Phone Number	
Email Address or Fax Number	

This form is not a substitute for evaluation or testing data. Please submit this form, along with the student's most current evaluation and test results/ scores and other supporting documents directly to the SAA Office. Documentation should be faxed to us at 610-929-6793 or mailed to us at:

Directions for Submitting this Form and Supporting Documentation:

Albright College
Office of Student Accessibility and Advocacy
1621 North 13th Street
Reading, PA 19604