Services for Students with Disabilities
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 SDS at (919) 530-6325 with questions.

The information below is to be completed and signed by the student.
I request and authorize North Carolina Central University, Office of Student Disability Services and/or my off-campus provider
(name) to release, fax, mail or discuss with each other information related to my registering with Student Disability Services (SDS).

Student Name

Student Signature

Email Address:

Date

Phone Number:

If the information above is left blank or is incomplete it may delay or prevent SSD 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.

      o Structured or unstructured interviews with student.
      o Interviews with other persons (i.e. parent, teacher, therapist).
      o Behavioral observations.
      o Neuropsychological testing. Attach documentation.
      o Psychoeducational testing. Attach documentation.
      o Other (Please specify). ____________________________

   b. Current treatment being received by student:

      o Medication management:
         Current medications: ____________________________
      o Outpatient therapy:
         Frequency:
      o Group therapy: ____________________________
         Frequency:
      o Other (please describe): ____________________________
c. Approximate onset of diagnosis:
   o Child- approximate age: __________
   o Adolescent- approximate age: __________
   o Adult- approximate age: __________
   o Unknown

Severity of symptoms
   o Mild
   o Moderate
   o Severe

Prognosis of disorder:
   o good
   o fair
   o 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**?

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<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>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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<td>Cognitive Processing</td>
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<td>Memory</td>
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<td>Processing Speed</td>
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<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>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?

- o Yes
- o No
- o I don’t know

________________________________________________________________________

If YES please explain:________________________________________________________________________
4. **Accommodations**

a. Please mark whether student has utilized accommodations in the past.
   - Yes- Please describe: _______________________________________________________
   - No
   - Don't Know

b. (Optional) Recommended educational accommodations:

   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
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   ______________________________________________________

   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.*

<table>
<thead>
<tr>
<th>Provider Information</th>
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<tbody>
<tr>
<td>I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.</td>
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<tr>
<td>Signature: ___________________________ Date: ___________________________</td>
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<tr>
<td>Print Name and Title: ___________________________________________________</td>
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<td>State of License: ___________________________ License Number: ___________________________</td>
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<tr>
<td>Address: ___________________________________________________</td>
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<tr>
<td>Street or P.O. Box: ___________________________ City: ___________________________ State: ___________________________ Zip: ___________________________</td>
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<td>Phone: ___________________________ Fax: ___________________________</td>
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</tbody>
</table>

All documentation is confidential and should be submitted to:

North Carolina Central University  
1801 Fayetteville Street  
Suite 120 Student Services Building  
Durham, NC 27707  
Attention: Director of Student Disability Services