CLAYTON STATE UNIVERSITY
Disability Resource Center

Documentation for ADHD

Clayton State University's Disability Resource Center provides academic services and accommodations for students with documented disabilities. The treating or diagnosing healthcare professional should complete this form. The Disability Resource Center will use this form to evaluate eligibility for academic accommodations, which includes 1) disability diagnosis as defined under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990, as amended (ADAAA); 2) aid in the determination of appropriate services and accommodations in the academic environment.

The healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so. All parts of this form must be completed as thoroughly and legibly as possible. Inadequate information, incomplete answers and/or illegible handwriting will delay the eligibility review process for the student.

The information provided by the health care professional will not become part of the student's educational records, but will remain in the student's confidential file in the Disability Resource Center. Upon request, this form may be released only to the student. In addition to the requested information, please attach any other information you think would be relevant to the student's academic needs.

After completing this form, sign it, complete the Healthcare Provider Information section on the last page and return it to the student, who will give it to the Disability Resource Center staff at Clayton State University.

To view the USG BOR disability documentation criteria, please visit the following website: https://www.usg.edu/academic_affairs_handbook/section3/C793.

STUDENT INFORMATION
(Completed by Student)

Name (Last, First, Middle): _____

Date of Birth: _____ Institution: _____

Status: ☐ Current Student ☐ Transfer Student ☐ Prospective Student

Home Phone: _____ Cell Phone: _____

Address: _____

State: _____ Zip Code: _____

E-mail Address: _____

DIAGNOSTIC INFORMATION
(Completed by Healthcare Provider)

Please provide responses to the following items by typing or writing in a legible fashion. Illegible forms will delay the documentation review process for the student.

1. DSM-V diagnosis:

   - ☐ **314.01 (F90.2) Combined presentation**: If both criteria for Inattention and Hyperactivity/Impulsivity are met for the past 6 months.
   - ☐ **314.00 (F90.0) Predominantly Inattentive presentation**: If criteria for Inattention is met but criteria for Hyperactivity/Impulsivity is not met for the past 6 months.
   - ☐ **314.01 (F90.1) Predominantly Hyperactivity/Impulsivity presentation**: If criteria for Hyperactivity/Impulsivity is met but criteria for Inattention is not met for the past 6 months.
   - ☐ **314.01 (F90.8) Other Specified ADHD**: Symptoms characteristic of ADHD cause significant impairment in social, occupational, or other areas of functioning are present but do not meet the full criteria for ADHD or any other neurodevelopmental disorders, and the clinician chooses to communication the specific reason why the full criteria of ADHD is not met.
   - ☐ **314.01 (F90.9) Unspecified ADHD**: Symptoms characteristic of ADHD cause significant impairment in social, occupational, or other areas of functioning are present but do not meet the full criteria for ADHD or any other neurodevelopmental disorders, and the clinician chooses <u>not</u> to communication the specific reason why the full criteria of ADHD is not met.

2. State the following:

   a. Date of diagnosis: _____

   b. Date of first contact with student: _____

   c. Date of last contact with student: _____

   d. Comorbid conditions: _____

3. Student's History

   a. AD/HD History (inattention and/or hyperactivity during childhood):
   Document symptoms that were present during early school years. Provide information supporting the diagnosis based on independent sources (e.g. past evaluations, school records, teacher reports). Please attach copies of previous psychological evaluations.

   _____

   _____

   _____

   _____

   _____

b. Medical History:
Provide relevant medical history. Is the student currently taking medication for AD/HD? Are they experiencing any side effects with this medication?

4. Student's Current Specific Symptoms
Please report ADHD symptoms listed in the DSM-V that the student currently exhibits that interfere with social, academic, and occupational functioning. Please attach copies of psychological evaluation and/or standardized rating scales used to determine diagnosis completed by independent observers in at least two settings (not including patient and clinician). *Examples of suggested assessment measures include: continuous performance tests (VIGIL, TOV, Conners, IVA) and Barkley Adult ADHD Rating Scale- IV (BAARS-IV).*

5. State the student's functional limitations based on the AD/HD diagnosis, *specifically in a classroom or educational setting*.

6. State specific recommendations regarding academic accommodations for this student, and a rationale as to why these accommodations/services are warranted based upon the student's specific functional limitations.

_____

_____

_____

_____

HEALTHCARE PROVIDER INFORMATION

Provider Signature: _____ Date: _____

Provider Name (Print): _____

Title: _____ License #: _____

[Attach Business Card Here]