UNLV | DISABILITY RESOURCE CENTER

University of Nevada, Las Vegas Disability Resource Center
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Autism Spectrum Disorder Verification Form

The Disability Resource Center (DRC) provides academic services and accommodations for students with diagnosed disabilities. It is the student's responsibility to provide documentation that identifies a diagnosed disability covered under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990.

DRC requires current and comprehensive documentation in order to determine appropriate services and accommodations. The outline below has been developed to assist the student in working with the treating or diagnosing healthcare professional(s) in obtaining the specific information necessary to evaluate eligibility for academic accommodations.

The healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so.

Forms must be completed as thoroughly as possible. Inadequate information, incomplete answers and/or illegible handwriting will delay processing and result in follow up contact with the healthcare professional.

The healthcare provider should attach any reports which provide additional related information (e.g. psycho-educational testing, neuropsychological test results, etc.). **If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted for documentation instead of this form.**

Please do not provide case notes or rating scales without a narrative that explains the results.

In addition to the requested information, please attach any other information you think would be relevant to the student's need for academic adjustments.

Complete the Healthcare Provider Information section on the last page and mail or fax it to the address provided above.

If you have questions regarding this form, please call the DRC office at 702-895-0866.

STUDENT SIGNED CONSENT FOR RELEASE OF INFORMATION
(Print or Type)

Name (Last, First, Middle): _____

Date of Birth:_____NSHE:_____

Status (check one):
- ☐ Current UNLV student
- ☐ Transfer student
- ☐ Prospective student

Local phone: (_____)_____-_____

Cell phone: (_____)_____-_____

UNLV E-Mail address: _____

Personal E-mail address:_____(for non-admitted students)

I hereby authorize my Healthcare Provider to release information requested in this document and further authorize DRC to communicate with the named individual or agency identified below to obtain clarification as needed to determine my eligibility for disability services at UNLV. This authorization is valid for 6 months.

Student Signature_____Date:_____

Parent Signature (If student is under 18):_____Date:_____

DIAGNOSTIC INFORMATION

(Please Print Legibly or Type)

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.

Date of Diagnosis:_____ Date of last clinical contact:_____

Please list all DSM-5 or ICD Diagnoses
Diagnoses:

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

In addition to DSM-V criteria, how did you arrive at your diagnosis?

- ☐ Structured or unstructured interviews with the student
- ☐ Interviews with other persons
- ☐ Behavioral observations
- ☐ Developmental history
- ☐ Educational history
- ☐ Medical history
- ☐ Neuro-psychological testing. Date(s) of testing? _____
- ☐ Psycho-educational testing. Date(s) of testing? _____
- ☐ Standardized or non-standardized rating scales Other. (Please specify)

_____

_____

What is the severity of the disorder? ○ Mild ○ Moderate ○ Severe

What is the expected duration of this disability?

_____

_____

_____

Is this student currently receiving therapy or counseling? If yes, what type of therapy/counseling and how often is the student seen?

_____

_____

_____

Please describe the student's symptoms relating to this diagnosis:

_____

_____

_____

What specific symptoms does the student have that might affect the student's academic performance?

_____

_____

_____

Major Life Activities Assessment:

Please check which of the following major life activities listed above are affected because of the impairment. Please indicate severity of limitations.

Life Activity	1-Negligible	2-Moderate	3-Substantial	Don't know
Communicating	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐
Hearing	☐	☐	☐	☐
Learning	☐	☐	☐	☐
Manual Tasks	☐	☐	☐	☐
Reading	☐	☐	☐	☐
Seeing	☐	☐	☐	☐
Thinking	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Working	☐	☐	☐	☐
Cognitive Processing	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Processing Speed	☐	☐	☐	☐
Meeting Deadlines	☐	☐	☐	☐
Attending Class	☐	☐	☐	☐
Organization	☐	☐	☐	☐
Reasoning	☐	☐	☐	☐
Stress	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Others:	☐	☐	☐	☐

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

_____

_____

_____

_____

What medications is the student currently taking? How effective is the medication? How might side effects, if any, affect the student's academic performance?

_____

_____

_____

_____

Please state specific suggestions regarding academic accommodations for this student, and a rationale as to why these accommodations are warranted based upon the student's functional limitations.

_____

_____

_____

_____

HEALTHCARE PROVIDER INFORMATION

Provider Signature:_____ **Date:**_____

Provider Name (Print):_____

Title:_____ **License or Certification #:**_____

Address:

_____

Phone #:_____ **Fax #:**_____

The information you provide will *not* become part of the student's academic records, but it will be kept in the student's file at DRC, where it will be held strictly confidential. Files are purged after 7 years in compliance with state requirements. This form may be released to the student at his/her request.