Autism Spectrum Disorder Verification Form

The My Place Enhanced Autism Support Program at Kutztown University has established the Verification Form for Autism Spectrum Disorder (ASD) to obtain current information from a qualified practitioner (e.g., physician, psychiatrist, psychologist) regarding a student's ASD symptoms, and their impact on the student and their need for accommodations in the higher education classroom setting. This Verification Form may supplement information that is provided in other reports, including full neuropsychological or psychoeducational evaluations or secondary school documentation, as required for admittance to the program, and can be used in place of . Any documentation, including this Verification Form, must meet Kutztown University Disability Services Office's guidelines for ASD. **The person completing this form may not be a relative of the student or hold power of attorney over the student.**

A summary of the guideline criteria for documenting ASD is as follows:

1. A clinical history of ASD
2. Symptoms involving social interaction and nonverbal communication, sensitivity to sensory input, fixated interests, and/or repetitive behaviors and adherence to routines determined through the administration of autism-specific behavioral evaluations
3. Functional limitations affecting an important life skill (academic, social, or occupational)
4. Assessment of global intellectual functioning and current academic functioning as measured by aptitude and achievement tests respectively
5. Exclusion of alternative diagnoses and
6. Summary and recommendations

Section I: Student Information (Please type information or print legibly)

Student Name:

Permanent Street Address:

City: State: ZIP:

Student ID: Date of Birth:

Pronouns: Phone Number:

Kutztown Email:

Submitting This Form

It is the responsibility of the student to ensure this form is submitted to the Disability Services Office at Kutztown University. The student will submit the form as part of the application process to the My Place Autism Support Program. With the permission of the student, this form can also be sent directly to the Disability Services Office via email to the Program Director, Megan Rutter (rutter@kutztown.edu) with the Student Name within the subject of the email; or via fax to the office at 610-683-1520

Adapted by permission from Bucks County Community College

Section II: Provider Section (Please type information or print legibly)

The remainder of this form must be completed by a licensed medical professional; credentials, a signature, and other information will be required in the final section.

Provider Name:
Practice/Office Name:

Contact with Student:

1. Date of initial contact with student:
2. Date of most recent contact with student:
3. On average, how often do you see this student?

Diagnostic Information:

A. *Clinical History*

Does the student have a clinical history (I.e. prior to age 12) of symptoms related to autism spectrum disorder? Yes No

At approximately what age did the student begin to exhibit ASD symptoms?

What date was the student diagnosed with ASD?

B. *ICD 10 Codes:*

	Please check the student's ICD 10 Code for ASD Type(s)
	F84.0 Autistic disorder
	F84.5 Asperger's syndrome
	F84.8 Other pervasive developmental disorders
	F84.9 Pervasive developmental disorder, unspecified

C. *Current Symptoms*

What is the severity of the disorder with regard to social impairments and rituals and repetitive behaviors based on the DSM-V severity rating scale?

Social Communication:		Restricted Interests & Repetitive Behaviors:	
Requiring support (Level 1)		Requiring support (Level 1)	
Requiring substantial support (Level 2)		Requiring substantial support (Level 2)	
Requiring very substantial support (Level 3)		Requiring very substantial support (Level 3)	

Please provide information regarding the student's current presenting symptoms:

Social interaction, reciprocal verbal communication, shared emotions and affect:	
Nonverbal communication:	
Hyper or hypo sensitivity to sensory input:	
Fixated interests:	
Repetitive behaviors and/or adherence to routines:	
Black and white thinking or rigidity in following rules:	

Is there clear evidence that the student's ASD symptoms are present in one or more settings, including the educational environment?

School functioning:	
Social functioning:	
Work functioning:	

Did you use an ASD-specific behavioral evaluation and/or ASD rating scale or checklist to obtain information about the student's symptoms and functioning in various settings?

a) If yes, which ASD behavioral evaluation and/or rating scale(s) or checklist(s) did you use?

b) If no, how did you reach your conclusion about the ASD diagnosis and treatment?

Please provide information regarding the student's global intellectual functioning and current academic functioning as measured by aptitude and achievement tests respectively. ***(Please note that a neuropsychological or psychoeducational evaluative report containing this information can supplement this Verification Form).***

1. Is this information contained within an accompanying report?

2. Aptitude: List
   a. the name of the comprehensive and current aptitude/cognitive instrument administered;
   b. the standard scores per subtest;
   c. the percentiles per subtest:

3. Achievement: List
   a. the name of the comprehensive and current achievement battery administered;
   b. the standard scores per academic area subtest.
   c. the percentiles per academic area subtest.

D. Behavioral Information

Does the student have a clinical history of verbal or physical aggression toward peers, family members, or adults? Yes No

a. If yes, please provide information regarding the student's history of aggression:

To your knowledge, does the student have a strategy for controlling their stress: Yes No

In your opinion, does this student have the behavioral, cognitive, and independent living skills required for college? Yes No

E. Other Diagnoses and ICD 10 Codes:

Does the student have any other diagnoses? Yes No

a. If yes, please list the DSM-V Codes and diagnosis in the space below:

ICD 10 Code:	Diagnosis

Does the student have a clinical history of hospitalizations related to a diagnosed psychological disorder? Yes No

a. Number of times student was hospitalized:

b. Please provide information regarding the student's history of hospitalization:

Educational History:

Did the student receive special education or intervention services at the K-12 level?

1. If yes, please check all that apply:

	Response to Intervention (RTI) Level 1		**504 Plan**
	Response to Intervention (RTI) Level 2		**Other:**
	Response to Intervention (RTI) Level 3		**Other:**
	Individualized Education Program (IEP)		**Other:**

Did the student have a modified curriculum at the K-12 level? Yes No

**** A modified curriculum means that the student had alternative or different exams and assignments than their peers.***

1. Did this modified curriculum accommodation stay in place until they graduated? Yes No

Functional Limitations and Recommended Accommodations:

Please list the student's current ASD symptoms and then indicate what reasonable academic accommodations would mitigate the symptoms listed. Examples of appropriate accommodations include extended test time, access to a distraction-reduced testing area, reasonable flexibility with assignment deadlines and attendance due to medical or mental health concerns, access to notetaking assistance, or housing accommodations such as a single room without a roommate or needing to reside in an air-conditioned environment.

Sample:

Symptom: (Example)
Difficulty tolerating distractions (i.e., low tolerance for noise)
Recommended Reasonable Accommodation(s):
Student should be provided a testing environment that limits distractions during tests, exams or quizzes.

Symptom:
Recommended Reasonable Accommodation(s):

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Symptom:
Recommended Reasonable Accommodation(s):

Please attach further recommendations on a separate sheet of paper, if necessary.

Section III: Provider's Certifying Professional Information

Professionals conducting the assessment, rendering a diagnosis, and providing recommendations for reasonable accommodations must be qualified to do so (e.g., licensed physician, psychiatrist, clinical psychologist). The provider signing this form must be the same person answering the above questions.

Provider Name:

Credentials:

License Number: State of Licensure:

Office Phone: Office Fax:

Office Street Address:

City: State: ZIP:

Provider Signature: Date:

By signing this form, you agree that all information herein is correct to the best of your knowledge as a medical practitioner. Once this document is received by the Disability Services Office, it will be utilized to gain information about the described student as it pertains to the Autism Support Program and will in no way affect their admission to the University; nor will any information herein be disclosed to other university staff, faculty, or students outside of the Disability Services Office.

Please either return this form to the student to submit to the Disability Services Office; fax it directly to 610-683-1520; or email it to the Director of the My Place Autism Support Program, Megan Rutter, at rutter@kutztown.edu.