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DISABILITY DOCUMENTATION FORM:

UTISMSPECTRUM DISORDER

The office of Disability Support Resources (DSR) strives to ensure that qualified persons with chronichealth conditions are accommodated, and if possible that their accommodations do not jeopardize successful therapeutic interventions. The office does not modify requirements that are essential to the program of instruction or provide accommodations for persons whose impairments do not substantially limit one or more major life function.

v Œ Á • University is required by Section 504 of the Rehabilitation Act and the Americans with Disabilities Act to provide effective auxiliary aids and services for qualified students with speaking,

arning, working, or taking care of oneself. It is important to note that a chronic health condition in and of itself does not necessarily constitute a disability. The degree

Diagnosis/Diagnoses: Please include DSM or ICD Codes and name of condition(s)

Date of onset:_____ Date of diagnosis: _____

Diagnostic Tools: How did you arrive at your diagnosis/diagnoses? Please check any relevant items below and attach assessment(s) to this form:

- ☐ Interviews with the client
- ☐ Interviews with other persons
- ☐ Behavioral observations
- ☐ Developmental history
- ☐ Psycho-educational testing
- ☐ Neuro-psychological testing
- ☐ High School IEP/504 Plan
- ☐ Self-rated or interviewed related scales
- ☐ Other

Prognosis

Expected Duration of Primary Condition: (Check One)

- ○ Permanent (check Permanent for conditions o

- ○

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Who is prescribing medication (include name and contact information) if different than professional completing this form W

What treatment and prescribed aids (i.e. counseling, therapy, support groups) are currently being used to address the diagnosis/diagnoses above?

t Z } is prescribing this treatment and prescribed aids (include name and contact information) if different than professional completing this form:

Is the client compliant with medication and prescribed aids as part of the trea33 (s)-0a667 (i)9J5Tj -0.1gibn.

Implications for Workplace or Academic/Student Life

Major Life Activity	Explanation of Impact Please describe the impact of your client's condition as it applies to each major life activity	Recommendations for Accommodations and ServiccET Q B2 1 T

Motivation		
Stress Management		
Organization		
Communication		
Other (Explain): _____		

Using the contact information on page one, print, sign below, and fax/send directly to Disability Support Resources.

Date: _____

Certifying Professional Signature: _____

Signature denotes content accuracy, adherence to professional standards and guidelines on page 1 of this document.

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