WASHBURN UNIVERSITY
SCHOOL OF LAW

VERIFICATION FORM for AUTISM SPECTRUM DISORDER (ASD)

Washburn University School of Law has established a Verification Form for Autism Spectrum Disorder (ASD) to obtain current information from a qualified practitioner (e.g., licensed physician, psychiatrist, clinical psychologist, or neuropsychologist) regarding a student's ASD symptoms, related medications, and their impact on the student and his or her need for accommodations. This Verification Form may supplement information that is provided in other reports, including full neuropsychological or psychoeducational evaluations or secondary school documentation, but must be completed for consideration of accommodation based on ASD.

A summary of the guideline criteria for documenting ASD is listed below (more information related to Washburn University School of Law's Disability Accommodations and Policy Statement can be found at: https://washburnlaw.edu/accommodations)

1. 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
6. Summary and recommendations

I. Student Information: **(Please Print Legibly or Type)**

Student's Name:

First: _____

Middle: _____

Last: _____

Date of Birth: _____ WU ID #: _____

Student's Home Address:

Street:

City:

State:

Zip:

Phone Number:

II. Provider Section:

1. Contact with Student

a. Date of initial contact with student:

b. Date of last contact with student:

2. Diagnosis

a. Clinical History:

i. Does the student have a clinical history of ASD symptoms?

Yes No

ii. Approximately at what age did the student start to exhibit ASD symptoms?

iii. At approximately what age was the student diagnosed with ASD?

b. Current Symptoms:

i. Please provide information regarding the student's current presenting symptoms with regard to the following:

social interaction, reciprocal verbal communication, shared emotions and affect	
nonverbal communication	
restricted, repetitive patterns of motor behavior, stereotypies	
inflexible adherence to routines	

hyper or hyporeactivity to sensory input	

ii. What is the severity of the disorder with regard to social communication impairments and restricted, repetitive patterns of behavior, based on the ***DSM-5*** 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)	

iii. Is there clear evidence that the student's ASD symptoms are interfering with or reducing the quality of functioning in at least one area?

Academic functioning:	
Social functioning:	
Work functioning:	

iv. 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?

Yes ☐ No ☐

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

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

c. 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)*.

i. Is this information contained within an accompanying evaluative report? Yes ☐ No ☐

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

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

d. ***DSM-5* Codes**:

i. Please include all pertinent diagnoses or rule-out diagnoses using *DSM-5* codes.

Principal Diagnosis: _____

Code: _____

Severity or Level of Impairment: _____

Descriptive Features: _____

Course: _____

Other Diagnoses: _____

Code: _____

Severity or Level of Impairment: _____

Descriptive Features: _____

Course: _____

WHODAS 2 Score (If given): _____

1. Medications

a. Is the student currently taking medication(s) for ASD symptoms? Yes ☐ No ☐

b. If yes, please provide information below for each medication the student is currently prescribed:

Medication/Dosage/Frequency (e.g., Fluoxetine (Prozac) 20 mg 1 x daily):	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication/Dosage/Frequency (e.g., Fluoxetine (Prozac) 20 mg 1 x daily):	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication/Dosage/Frequency (e.g., Fluoxetine (Prozac) 20 mg 1 x daily):	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication/Dosage/Frequency (e.g., Fluoxetine (Prozac) 20 mg 1 x daily):	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

2. Functional Limitations and Recommended Accommodations

a. Please list the student's current ASD symptoms and indicate what reasonable academic accommodations would mitigate the symptom listed.

Example: *A student may have difficulty tolerating distractions during exams and would benefit from a distraction-reduced environment to take tests.*
Learning Difficulty: *Difficulty tolerating distractions (i.e., low tolerance for noise)*
Recommended Reasonable Accommodation(s): *Distraction-reduced testing environment*

Symptom:
Recommended Reasonable Accommodation(s):

Symptom:
Recommended Reasonable Accommodation(s):

Symptom:
Recommended Reasonable Accommodation(s):

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, or neuropsychologist). The provider signing this form must be the same person answering the above questions.

Provider's Name:

First:

Middle:

Last:

Credentials:

License Number:

State of Licenser:

Street Address:

City:

State:

Zip:

Phone Number:

Email Address:

Can this completed Verification Form be released to the student? Yes No

Signature of Provider: Date:

Submitting this Form:

Upon completion, this form should be returned to Shelby Grau, Director of Compliance and Administration, Washburn University School of Law, Room 331A, 1700 SW College Ave., Topeka, KS 66621.