FRANCISCAN UNIVERSITY OF STEUBENVILLE

GUIDELINES FOR DOCUMENTATION

VERIFICATION OF AUTISM SPECTRUM DISORDER (ASD)

The Office of Student Success provides accommodations to students diagnosed with a disability that substantially impacts one or more major life functions. To determine eligibility for services and appropriate accommodations, current and comprehensive documentation of the disability from a licensed professional who is credentialed to perform such evaluation is required. If you have any questions pertaining to documentation needs, feel free to contact **The Office of Student Success at (740) 284-5263 or Email keasterday@franciscan.edu.**

STUDENT INFORMATION: ****** To be completed by the student ******

Full Legal Name: _____

Date of Birth: _____ Cell Phone: _____

FUS ID#: _____ FUS Email: _____ @student.franciscan.edu

Address: _____

_____

MEDICAL INFORMATION: ****** To be completed by the diagnosing professional ******

Part I. Diagnosis History

1. What is the DSM diagnosis, date of diagnosis, and last contact with the student?

2. What is the severity of the disorder? ☐ Mild ☐ Moderate ☐ Severe

3. Did you use an autism-specific behavioral evaluation and/or ASD rating scale to reach your diagnosis?
   ☐ Yes ☐ NO

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

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

Part II. Current Symptoms

4. Please provide information regarding the student's current presenting symptoms, such as social interaction, verbal/nonverbal communication, sensitivity to sensory input, fixated interests, repetitive behaviors, and/or adherence to routines:

Part III. Functional Limitations

5. Please describe the functional limitations of the disorder for this student in an educational setting and list any recommendations you have for academic accommodations.

6. Please describe the functional limitations of the disorder for this student in a residential setting and indicate what housing accommodations might mitigate the symptoms.

7. Is the student current taking medication(s) for ASD symptoms? If yes, please describe the side effects that impact the student's functioning (e.g., concentration, sleeping, recall ability, eating, etc.)

PROVIDER INFORMATION:

Signature: _____ Date: _____

Print Name and Title: _____

State of License: _____ License Number: _____

Address: _____

Telephone: _____

Once completed, please return this form back to the student *so that they may upload it with their OSS Disability Services Application (found on the FUS website).*
If you have questions regarding this form, please call OSS at 740-284-5263.

REVISED 02/19