UNIVERSITY OF WISCONSIN – LA CROSSE
The ACCESS Center

VERIFICATION OF
AUTISM SPECTRUM DISORDER

The ACCESS Center provides services to students with Autism Spectrum Disorders. To determine eligibility for services, this office requires **current and comprehensive documentation** of this disorder from the diagnosing **psychiatrist, psychologist, neurologist or other licensed mental health professional currently treating the student.**

Please Print Legibly

Student Name: ____

Date Completed: ____/____/____ Student's Date of Birth: ____/____/____

1. DSM-5 diagnosis: ____

2. Date of Diagnosis: ____/____/____

   First contact with student: ____/____/____ Last contact with student: ____/____/____

3. In addition to DSM-5 criteria, how did you arrive at your diagnosis?
   - ☐ Structured or unstructured clinical interview with the student
   - ☐ Interviews with other persons
   - ☐ Behavioral observations
   - ☐ Developmental history
   - ☐ Educational history
   - ☐ Medical history
   - ☐ Neuropsychological testing (dates of testing) ______________________________
     Please attach diagnostic report of testing
   - ☐ Psychoeducational testing (dates of testing) ______________________________
   - ☐ Standardized or non-standardized rating scales
   - ☐ Other (Please specify)

   ____

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4. What is the severity of the condition? Please check one:

☐ Mild ☐ Moderate ☐ Severe

Explain Severity: ____

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5. Please check the major life activities/functional limitations, both physical and academic, which are impacted by the disability and the degree of severity.

	Mild	Moderate	Severe	Not an issue
Sitting				
Standing				
Walking				
Breathing				
Reaching				
Lifting				
Performing Manual Tasks				
Maintaining Stamina				
Communication: Speaking				
Communication: Writing				
Communication: Reading				
Communication: Hearing/Listening				
Seeing				
Learning				
Thinking/Reasoning				
Calculating				
Memorizing				
Cognitive Processing				
Processing Speed				
Auditory Processing				
Concentrating				
Easily Distracted				
Organization				
Meeting Deadlines				
Attending Class Regularly				
Managing Stress				
Sleeping				
Interacting with Instructors				
Interacting with Peers				
Emotional Expression				
Understanding Verbal Direction				
Other:				
Other:				

Explanation of any major life activities/functional limitations that fall into the severe range.

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7. Is this student currently receiving therapy or counseling?

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

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9. Describe any situation or environmental conditions that might lead to an exacerbation of the condition.

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10. State specific recommendations regarding academic accommodations for this student, and a rationale as to why these accommodations/services are warranted based upon the student's functional limitations. Indicate why the accommodations are necessary (e.g. if a note taker is suggested, state reasons for this request related to the student's diagnosis).

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6. Is the student's condition such that it may require them to take fewer credits than what is considered a full time course load? Please explain.

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11. Are there any other considerations that should be taken into account when determining appropriate accommodations and interventions for the student, e.g. housing, transportation, assistive technology, etc.?

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12. If any co-morbid conditions exist, please describe.

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Signature: ______________________________ **Date:** ____________

Print Name and Title: ______________________________

License #: ______________________________

Address: ______________________________

Telephone: ______________________________

Please send or fax this information to the address indicated below:

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The ACCESS Center
124 Wimberly Hall
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La Crosse, WI 54601
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Fax: (608) 785-6910