Andrews University
Student Success Center

Disabilities Services Coordinator
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DISABILITY DOCUMENTATION FORM:

AUTISM SPECTRUM DISORDER

The office of Disability Support Resources (DSR) strives to ensure that qualified persons with chronic health 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.

Andrews 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 documented disabilities if such accommodations are needed to provide equitable access to the University's programs and services. Federal law defines a disability as "a physical or mental impairment that substantially limits one or more major life activities." Major life activities are defined as the ability to perform functions such as walking, seeing, hearing, speaking, breathing, learning, 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 of impairment must be significant enough to "substantially limit" one or more major life activities.

This form is designed to allow us to achieve these goals. Persons who wish to receive accommodations due to a chronic health condition need to have this form filled out by a certified physician. The physician completing this form must have first-hand knowledge of the person's condition, must have experience diagnosing and treating condition, and will be an impartial professional who is not related to the patient. **NOTE: This form may not be used as documentation for Assistance Animals.** Please complete all blanks on this document. If any information is left unanswered, this documentation will not be accepted.

The Americans with Disabilities Act (ADA) defines disability as "a physical or mental impairment that substantially limits one or more major life activities, a record of such impairment, or being regarded as having such an impairment." Disabilities involve substantial limitations and are distinct from common conditions not substantially limiting major life activities.

Client Information (to be completed by the client)

Last Name: _____ First _____ Middle Initial _____

Date of Birth: _____ Client Student ID#: _____

Certifying Professional (to be completed by the certifying professional)

Certifying Professional's Full Name: _____

Credentials/Specialization: _____

License Type: _____

License #: _____ State _____ Exp. Date _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Phone

Area Code: (_____) Phone Number _____

Fax Area Code: (_____) Fax Number _____

Email: _____

Office web address: _____

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 of 6 months or more with expected duration into the foreseeable future)

○ Temporary (include expected duration and rationale for temporary status)

Characteristics of Limiting Condition(s): (Check All That Apply)

☐ Stable ☐ Episodic ☐ Slow Progression ☐ Rapid Progression ☐ Improving

Additional comments/information

Medication, Treatment, and Prescribed Aids

What medication(s) are currently being used to address the diagnosis/diagnoses above? For each prescribed medication, describe side-effects that may adversely affect the client's academic or workplace performance.

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

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

Who 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 treatment plan? If no, please explain:

Date of last appointment: _____

How often does your client receive treatment?

☐ Weekly ☐ Monthly ☐ Annually ☐ As needed

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 Services** Please provide specific recommendations to address impacted major life activities
Concentration		
Long Term Memory		
Short Term Memory		
Sleeping		
Eating		
Listening		
Social Interactions		
Self-Care		
Managing Internal Distractions		
Managing External Distractions		
Time Management		

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.
Typing your first and last name in the field above indicates your signature.