

UNIVERSITY OF WISCONSIN-PARKSIDE
DISABILITY SERVICES OFFICE

900 Wood Road, WYLL D175, Kenosha WI 543141
Tel: (262) 595-2610 Fax: (262) 595-2716

CERTIFICATION OF ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

The student named below has applied for services from the Disability Services (DS) Office at UW-Parkside. In order to provide reasonable and appropriate services for students with ADHD, current and comprehensive information documenting the functional impact of the disability is required. This form is intended to assist clinicians in providing sufficient information so that eligibility for services can be determined. The information you provide will not become part of the student's educational records and will be kept in the student's confidential file at DS Office. In addition to the requested information, please attach any additional information; for example, your report and any test results. Thank you for your assistance.

1. Name of Student: _____ Today's Date: _____

2. Date of your last contact with student: _____

3. What is your DSM-IV multi-axial diagnosis for this student?

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

4. Please indicate medications for ADHD that have been prescribed for this student.

Medication(s)/dosage:

Date first prescribed:

5. What methods or testing instruments did you use to arrive at your diagnosis? Please check all relevant items **adding brief notes that you think might be helpful to us as we determine which accommodations services are appropriate for the student.**

Structured or unstructured clinical interviews with the individual

Interviews with other individuals

Developmental history

Medical history

Neuro-psychological/Psycho-educational testing – Date(s) of testing?

Standardized or non-standardized rating scales

Other (please specify)

6. Do you recommend additional assessment for:

• Learning disabilities

• AODA

• Sleep disorder

• Eating disorder

• Other (please specify)

Yes

No

7. Please assess degree of functional impairment due to ADHD demonstrated by your patient:

1 = Negligible 2 = Moderate 3 = Substantial 4 = Severe UN = Unknown

1) Time management	1	2	3	4	UN
2) Organizational skills (physical and/or cognitive)	1	2	3	4	UN
3) Task persistence	1	2	3	4	UN
4) Memory skills	1	2	3	4	UN
5) Reading (fluency, comprehension)	1	2	3	4	UN
6) Quantitative skills	1	2	3	4	UN
7) Written expression	1	2	3	4	UN
8) Employment/work skills	1	2	3	4	UN
9) Self esteem/social skills	1	2	3	4	UN
10) Other	1	2	3	4	UN

8. Please describe the functional limitations this student encounters when using medication.

9. Please describe an appropriate intervention plan and indicate how the plan will be managed:

Treatment/Intervention

- Pharmacotherapy
- Compensatory strategies (please specify)
- Academic study skills (please specify)
- Brief psychotherapy
- Long-term psychotherapy
- Other (please specify)

Provide

Needs Referral

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

10. Please indicate which accommodations if any, may be beneficial to this student.

- Distraction free test environment
- Extended test time
- Notetaking support
- Reduced credit load
- Other

11. Is there anything else you would like us to know about this student?

Signature of Professional

Date

Professional's Name (printed) and Title

License No.

Telephone No.

Address

Fax No.