Verification Form for Students with Psychological Disabilities
And Attention-Deficit/Hyperactivity Disorder

This form is intended to assist in meeting our documentation requirements for these disabilities. However, if not thoroughly completed, it may not be sufficient as the sole form of documentation provided. Please refer to the “Guidelines for Documenting Psychological Disabilities” or “Guidelines for Documenting Attention-Deficit/Hyperactivity Disorder” for comprehensive documentation requirements and additional information. To ensure the provision of reasonable and appropriate accommodations, students requesting services must provide documentation of the disability. This documentation should provide information regarding the onset, longevity and severity of symptoms, as well as the specifics describing how it has interfered with educational achievement. Please include a copy (including test scores) of any relevant psychoeducational or neuropsychological reports. To standardize our gathering of information, it is recommended that you complete the following questions, even if the material has already been included in your full evaluation. All information will be kept confidential. Please feel free to contact SDS at (813) 974-4309.

If documentation is not available or is older than 5 years, please contact SDS and request an in-person meeting. The purpose of the meeting is to discuss possible eligibility for services including history of accommodations and documentation of options.

The information below is to be completed and signed by the Provider

I request ___________________________________________ to release, fax, or mail
(Provider’s Name)
information relating to my condition/diagnosis to the office of Students with Disabilities Services (SDS),
University of South Florida.

______________________________________________________________
Student Name

______________________________________________________________
Student “U” Number

______________________________________________________________
Student Signature Date

May 2016
1. **Please list all DSM-V or ICD Diagnoses (text and code):**

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<tbody>
<tr>
<td>AXIS I:</td>
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<td>AXIS II:</td>
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<td>AXIS III:</td>
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<td>AXIS IV:</td>
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<td>AXIS V (GAF score) optional:</td>
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a. Date diagnosed: ________________
b. Date of your last clinical contact with student: ________________

2. **Evaluation**

   a. How did you arrive at this diagnosis? Please check all relevant items below, adding brief notes that you think might be helpful to us as we determine eligibility for accommodations.

   - Structured or unstructured interviews with student.
   - Interviews with other persons (i.e. parent, teacher, therapist).
   - Behavioral observations.
   - Neuropsychological testing. Attach documentation.
   - Psychoeducational testing. Attach documentation.
   - Other (Please specify). ____________________________________________

   b. Current treatment being received by student:

   - Medication management:
     - Current medications: ____________________________________________
   - Outpatient therapy:
     - Frequency: ____________________________________________
   - Group therapy:
     - Frequency: ____________________________________________
   - Other (please describe):________________________________________

   c. Approximate onset of diagnosis:

   - Child- approximate age:____________________
   - Adolescent- approximate age: ________________
   - Adult- approximate age:______________________
   - Unknown

   d. Severity of symptoms

   - Mild
   - Moderate
   - Severe
e. Prognosis of disorder:
- [ ] Good
- [ ] Fair
- [ ] Poor
- [ ] Please explain: ______________________________________________________
  ______________________________________________________
  ______________________________________________________

3. Functional Limitations

a. Does this condition significantly **limit one or more of the following major life activities?**

<table>
<thead>
<tr>
<th></th>
<th>No Impact</th>
<th>Moderate Impact</th>
<th>Substantial Impact</th>
<th>Don't Know</th>
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</thead>
<tbody>
<tr>
<td>Communicating</td>
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<td>Concentrating</td>
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<td>Hearing</td>
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<td>Learning</td>
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<td>Manual Tasks</td>
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<td>Reading</td>
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<td>Seeing</td>
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<td>Walking</td>
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<td>Working</td>
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<td>Other:</td>
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b. Please check the current **functional limitations or behavioral manifestations** for this student:

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<tr>
<th></th>
<th>Not an Issue</th>
<th>Moderate Issue</th>
<th>Substantial Issue</th>
<th>Don’t Know</th>
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<tbody>
<tr>
<td>Cognitive Processing</td>
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<tr>
<td>Memory</td>
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<td>Processing Speed</td>
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<tr>
<td>Meeting Deadlines</td>
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<tr>
<td>Attending class</td>
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<td>Organization</td>
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<td>Reasoning</td>
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<td>Stress</td>
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<td>Sleep</td>
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<td>Appetite</td>
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<td>Other:</td>
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c. Please describe in detail any functional limitations that fall into the substantial range.
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

____________________
________________________________________________________


d. Special considerations, e.g. medication side effects:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________


e. COURSE LOAD REDUCTION: Is the student’s condition such that it may require them to take fewer than what is considered a full-time course load?

☐ Yes  ☐ No  ☐ I don’t know

If YES please explain___________________________________________________
______________________________________________________________________________
______________________________________________________________________________

4. Accommodations

a. Please mark whether student has utilized accommodations in the past.

☐ Yes- Please describe:___________________________________________________

☐ No

☐ I don’t know

b. (Optional) Recommended educational accommodations: ______________________________
______________________________________________________________________________
______________________________________________________________________________


c. (Optional) Please provide any additional information you feel will be useful in determining the nature and severity of the student’s disability, and any additional recommendations that may assist in determining appropriate accommodations and interventions:
______________________________________________________________________________
______________________________________________________________________________
Thank you for your help in providing this information so that we may begin services as soon as possible. Please complete the provider information below. This form should be signed and returned via fax or mail to the SDS office at the address shown at the end of this document.

All documentation submitted to SDS is considered confidential.

**Provider Information**

I certify, by my signature below, that I am not a family member of the student. My signature also certifies that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

Signature: ___________________________ Date: __________________________

Print Name and Title: __________________________

State of License: _______________ License Number: __________________________

Address: __________________________________________________________

(Street or P.O. Box) (City) (State) (ZIP)

Phone: __________________________ Fax: __________________________

Please return this form, signed and sealed, to:

The University of South Florida
Students with Disabilities Services
4202 E. Fowler Ave., SVC 1133
Tampa, FL 33620-6923
Phone: 813-974-4309
Fax: 813-974-7337

Attach Provider Business Card Here