Verification Form

Autism Spectrum Disorder

Bucks County Community College | Accessibility

Bucks County Community College's Accessibility Office (TAO) has established the Verification Form for Autism Spectrum Disorder (ASD) to obtain current information from a qualified practitioner (e.g., physician, psychiatrist, psychologist) regarding a student's ASD symptoms, related medications, and their impact on the student and his or her need for accommodations in the higher education classroom setting. This Verification Form may supplement information that is provided in other reports, including full neuropsychological or psychoeducational evaluations or secondary school documentation. Any documentation, including this Verification Form, must meet Bucks County Community College's TAO guidelines for ASD. The person completing this form may not be a relative of the student or hold power of attorney over the student.

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A summary of the guideline criteria for documenting ASD is as follows:

1. A clinical history of ASD
2. Symptoms involving social interaction and nonverbal communication, sensitivity to sensory input, fixated interests, and/or repetitive behaviors and adherence to routines determined through the administration of autism-specific behavioral evaluations
3. Functional limitations affecting an important life skill (academic, social, or occupational)
4. Assessment of global intellectual functioning and current academic functioning as measured by aptitude and achievement tests respectively
5. Exclusion of alternative diagnoses and
6. Summary and recommendations

Section I: Student Information (Please type information or print legibly)

Student Name: _____
Last First Middle

Student ID: _____ **Date of Birth:** _____

Cell Phone: _____ **Home Phone:** _____

Bucks Email: _____ **Home Email:** _____

Permanent Street Address: _____

City: _____ **State:** _____ **Zip:** _____

(If different from Permanent Street Address)

Local Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Section II: Provider Section (Please type information or print legibly)

A. Contact with the Student:

Date of initial contact with the student: _____

Date of last contact with the student: _____

B. Diagnosis Information:

1. Clinical History

Does the student have a clinical history (i.e., prior to age 12) of ASD symptoms? ☐ **YES** ☐ **NO**

Approximately at what age did the student start to exhibit ASD symptoms? _____

What date was the student diagnosed with ASD symptoms? _____ Month _____ Year

2. Current Symptoms

a. Please provide information regarding the student's current presenting symptoms:

Social interaction, reciprocal verbal communication, shared emotions and affect:	
Nonverbal communication:	
Hyper or hypo sensitivity to sensory input:	
Fixated interests:	
Repetitive behaviors and/or adherence to routines:	
Black and white thinking or rigidity in following rules:	

b. What is the severity of the disorder with regard to social impairments and rituals and repetitive behaviors based on the DSM-V severity rating scale?

Social Communication:		**Restricted Interests & Repetitive Behaviors:**	
Requiring support (Level 1)	☐	Requiring support (Level 1)	☐
Requiring substantial support (Level 2)	☐	Requiring substantial support (Level 2)	☐
Requiring very substantial support (Level 3)	☐	Requiring very substantial support (Level 3)	☐

c. Is there clear evidence that the student's ASD symptoms are present in one or more setting including the educational environment?

School functioning:	
Social functioning:	
Work functioning:	

d. Did you use an ASD-specific behavioral evaluation and/or ASD rating scale or checklist to obtain information about the student's symptoms and functioning in various settings? ☐ **YES** ☐ **NO**

1) If yes, which ASD behavioral evaluation and/or rating scale(s) or checklist(s) did you use?

2) If no, how did you reach your conclusion about the ASD diagnosis and treatment?

e. Please provide information regarding the student's global intellectual functioning and current academic functioning as measured by aptitude and achievement tests respectively. ***(Please note that a neuropsychological or psychoeducational evaluative report containing this information can supplement this Verification Form).***

1) Is this information contained within an accompanying evaluative report? ☐ **YES** ☐ **NO**

2) Aptitude: List (a) the name of the comprehensive and current aptitude/cognitive instrument administered; (b) the standard scores per subtest; and (c) the percentiles per subtest.

3) Achievement: List (a) the name of the comprehensive and current achievement battery administered; (b) the standard scores per academic area subtest; and (c) the percentiles per academic area subtest.

3. ICD 10 Codes:

Please check the student's ICD 10 Code for ASD Type(s)	
☐	**F84.0** Autistic disorder
☐	**F84.5** Asperger's syndrome
☐	**F84.8** Other pervasive developmental disorders
☐	**F84.9** Pervasive developmental disorder, unspecified

4. Behavioral Information:

a. Does the student have a clinical history of alcohol abuse? ☐ **YES** ☐ **NO**

1) Please provide information regarding the student's history of alcohol abuse.

b. Does the student have a clinical history of drug abuse? ☐ **YES** ☐ **NO**

1) Please provide information regarding the student's history of drug abuse.

c. Does the student have a clinical history of verbal or physical aggression toward peers, family members or adults? ☐ **YES** ☐ **NO**

1) Please provide information regarding the student's history of verbal or physical aggression.

5. Military Service

a. Has the student served in the military? ☐ **YES** ☐ **NO**

1) What branch of the military did the student serve with?

☐	United States Air Force	☐	United States Coast Guard	☐	United States Navy
☐	United States Army	☐	United States Marine Corp.		

b. Is the diagnosis related to their service in the military? ☐ **YES** ☐ **NO**

1) Please provide information regarding the student's history of physical health needs related to their military service.

c. Is the receiving treatment through United States Department of Veterans Affairs? ☐ **YES** ☐ **NO**

1) At what location of the VA does the student receive services? _____

6. World Health Organization Disability Assessment Schedule 2.0

a. Does the student have a WHODAS 2 Score? ☐ **YES** ☐ **NO**

b. If yes, please provide the score here: _____

7. Other Diagnosis and ICD 10 Codes?

a. Does the student have any other diagnosis? ☐ **YES** ☐ **NO**

b. If yes, please list the DSM-V Codes and the diagnosis in the space provided below:

ICD 10 Code:	Diagnosis

c. Does the student have a clinical history of hospitalizations related to a diagnosed psychological disorder? ☐ **YES** ☐ **NO**

Number of times student was hospitalized: _____

1) Please provide information regarding the student's history of hospitalization(s).

d. Does the student have a clinical history of suicidal ideation or has the student attempted to take their own life? ☐ **YES** ☐ **NO**

1) Number of times student threatened suicide or has reported suicidal ideation: _____

2) Number of times student attempted suicide: _____

3) Please provide information regarding the student's history of suicidal ideation or suicide attempt(s).

C. Family History:

1. Does the student have a family history of physical health impairments? ☐ **YES** ☐ **NO**

2. If yes, please check all that apply:

☐	**Mother**	☐	**Father**	☐	**Siblings**
☐	**Grandparents (Maternal)**	☐	**Grandparents (Paternal)**	☐	**Aunts (Maternal)**
☐	**Uncles (Maternal)**	☐	**Aunts (Paternal)**	☐	**Uncles (Paternal)**
☐	**Cousins (Maternal)**	☐	**Cousins (Paternal)**		

a. If yes, please list the family history of any health disorders.

3. Does the student have a family history of any psychological disorders? ☐ **YES** ☐ **NO**

4. If yes, please check all that apply:

☐	**Mother**	☐	**Father**	☐	**Siblings**
☐	**Grandparents (Maternal)**	☐	**Grandparents (Paternal)**	☐	**Aunts (Maternal)**
☐	**Uncles (Maternal)**	☐	**Aunts (Paternal)**	☐	**Uncles (Paternal)**
☐	**Cousins (Maternal)**	☐	**Cousins (Paternal)**		

a. If yes, please list the family history of any psychological disorders.

D. Educational History:

1. Did the student receive special education or intervention services at the K-12 level? ☐ **YES** ☐ **NO**

2. If yes, please check all that apply:

☐	**Response to Intervention (RTI) Level 1**	☐	**504 Plan**
☐	**Response to Intervention (RTI) Level 2**	☐	**Other:**
☐	**Response to Intervention (RTI) Level 3**	☐	**Other:**
☐	**Individualized Education Program (IEP)**	☐	**Other:**

3. Did the student have a modified curriculum at the K-12 level? ☐ **YES** ☐ **NO**

**** A modified curriculum means that the student had alternative or different exams and assignments than their peers.***

E. Assistive Technology and Durable Medical Equipment:

1. Does the student use assistive technology? ☐ **YES** ☐ **NO**

a. If yes, please list the assistive technology.

2. Does the student use durable medical equipment? ☐ **YES** ☐ **NO**

a. If yes, please list the durable medical equipment.

D. Medication(s):

1. Is the student currently taking medication(s) for any symptoms related to the diagnosis? ☐ YES ☐ NO
2. Does the student have a history of noncompliance with medication? ☐ YES ☐ NO
   a. If yes, please list the behaviors or incidents of noncompliance with medication in the student's history.

3. If yes, please provide information below for each medication the student is currently prescribed:

Medication • Dosage • Frequency (e.g., Fluoxetine (Prozac) 20 mg 1 x daily):	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication • Dosage • Frequency	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication • Dosage • Frequency	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication • Dosage • Frequency	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication • Dosage • Frequency	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication • Dosage • Frequency	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

E. Functional Limitations and Recommended Accommodations:

1. Please list the student's current ASD symptoms and then indicate what reasonable academic accommodations would mitigate the symptom listed.

2. **Sample:**

Symptom: (Example)
Difficulty tolerating distractions (i.e., low tolerance for noise)
Recommended Reasonable Accommodation(s):
Student should be provided a testing environment that limits distractions during tests, exams or quizzes.

Symptom:
Recommended Reasonable Accommodation(s):

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Symptom:
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Symptom:
Recommended Reasonable Accommodation(s):

Section III: Provider's Certifying Professional Information

(Please type information or print legibly)

Professionals conducting the assessment, rendering a diagnosis, and providing recommendations for reasonable accommodations must be qualified to do so (e.g., licensed physician, psychiatrist, clinical psychologist). The provider signing this form must be the same person answering the above questions.

Provider Name: _____
Last First Middle

Credentials: _____

License Number: _____ **State of Licenser:** _____

Office Phone: _____ **Office Fax:** _____

Office Email: _____ **Office Website:** _____

Office Street Address: _____

_____

City: _____ **State:** _____ **Zip:** _____

Provider Signature: _____ **Date:** _____

Section IV: Submitting This Form

It is the responsibility of the student to submit the form to the Accessibility Office (TAO) at Bucks County Community College where the student is enrolled. The student will submit the form to the Learning Specialist during their intake appointment when they register with TAO. Students will also be required to meet with a Learning Specialist if they would like to update their accommodations using the verification form or any other form of documentation.

Section V: How to Make an Intake Appointment

Students are encouraged to call or email the Accessibility Office (TAO) to schedule an appointment. Intake appointments are only done in person. There are certain times of year that appointment waiting times can be up to six weeks. The student identification number and Bucks email is required for students to obtain an intake appointment. Students are encouraged to contact TAO as soon as possible to ensure that their accommodations are approved and put into place as soon as possible. TAO's contact information is as follows:

Phone: (215) 968-8182

Email: accessibility@bucks.edu

Office: Bucks County Community College
275 Swamp Road
Rollins Center • Student Services Office • Room 001
Newtown, Pennsylvania 18940

Appointments can be scheduled for the Upper Bucks (Perkasie) and Lower Bucks (Bristol) campuses. TAO Learning Specialists are on each of the satellite campuses one day per week. The student should inform the TAO team member if they have a campus preference.

Information regarding the Accessibility Office (TAO), accommodations and assistive technology (AT) at Bucks County Community College can be found at https://www.bucks.edu/resources/campusresources/accessibility/. Please visit our website for the latest information and updates as they are made available. If you have any questions, please feel free to call us (215) 968-8182.