Verification Form for Diagnosis of Attention Deficit/Hyperactivity Disorder
(To be completed by diagnosing/current physician or certified professional)

Name: ________________________________

DOB or Student ID: ____________________

The above-mentioned student has requested academic accommodations from the Office of Disability Services at Texas State University-San Marcos on the basis of Attention Deficit/Hyperactivity Disorder (ADHD). In order to determine whether the student qualifies for services based on university criteria, the following information is needed. Please return the completed form to the address above, include a copy of the complete psychological report, medical and/or psychiatric records, if available. The student and/or unqualified individuals should not complete the information on this form.

All parts of this form must be completed before student can be considered for services.

1. DSM-IV diagnosis:  
   [ ] ADHD, predominantly inattentive type  
   [ ] ADHD, combined type  
   [ ] ADHD, predominantly hyperactive-impulsive type  
   [ ] ADHD Not Otherwise Specified

2. What is the severity of the condition?  
   [ ] mild  
   [ ] moderate  
   [ ] severe

3. Initial date of diagnosis: ________________________________  
   month/day/year

4. In addition to DSM-IV criteria, how did you arrive at your diagnosis? (2 or more needed)  
   _____clinical interview with student  
   _____behavioral observation  
   _____history  
   _____interviews with other person  
   _____psychological testing (please attach results)  
   _____rating scales (please attach copy)  
   _____other (please specify below)

   ________________________________________________________________

5. Date of first contact with student: ________________________________
Date of last contact with student:____________________________________

-SEE BACK-

6. Please list any co-morbid diagnoses below, or write N/A if non-applicable:

*Axis I:_________________________ Axis III:_________________________

_________________________ Axis IV:_________________________

Axis II:_________________________ Axis V:_________________________

* If ADHD is not this student’s primary diagnosis, please specify primary from above.

7. List any medications currently prescribed:

____________________________________________________________________
____________________________________________________________________

8. Describe the student’s functional limitations on learning and the degree to which it impacts the individual in the academic setting for which accommodations are being requested.

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Certifying Professional – The student and/or unqualified individuals should not complete this form. By signing below, you are confirming that you provided the information above.

Name__________________________________________________________ License #______________________

Address________________________________________________________ Phone__________________________

_______________________________________________________________ Date__________________________

Signature________________________________________________________

Thank you for your time and prompt reply so that we may begin services as soon as possible. If you have questions or need additional information, please contact an ODS staff member at 512-245-3451.