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.

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1. DSM-V diagnosis:
   ADHD, predominantly inattentive presentation
   ADHD, combined presentation
   ADHD, predominantly hyperactive/impulsive presentation
   Other Specified ADHD
   Unspecified ADHD

2. What is the severity of the condition?
   Mild Moderate Severe

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

4. In addition to DSM-V 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)

OFFICE OF DISABILITY SERVICES
601 University Drive | LBJ Student Center 5-5.1 | San Marcos, Texas 78666-4616
phone: 512.245.3451 | *fax:* 512.2453452 | WWW.TXSTATE.EDU
This letter is an electronic communication from Texas State University.
MEMBER THE TEXAS STATE UNIVERSITY SYSTEM™

5. Date of first contact with student:

Date of last contact with student:

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

Code and Disorder Name: Code and Disorder Name:

Code and Disorder Name: Code and Disorder Name:

* 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 (print/type), you are confirming that you provided the information above.

Certifying Professional (Please print or type)

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.