Disability Services
disabilityservices@byuh.edu
808-675-3518

VERIFICATION FORM for AUSTIM SPECTRUM DISORDERS (ASD)

BYU–Hawaii supports a climate of equal opportunity in its programs, activities, and services according to applicable law, including providing accommodations for students with disabilities. As part of the process for requesting accommodations, a student must provide documentation from a qualified practitioner who is the primary treating professional (e.g., licensed physician, psychiatrist, clinical psychologist, neuropsychologist) regarding the student's ASD symptoms, related medications, and their impact on the student's major life activity and their need for accommodations. 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 BYUH DS guidelines for Autism Spectrum Disorders (ASD).

A summary of the guideline criteria for documenting learning disorders is listed below.

1. 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
6. Summary and recommendations

This form will be reviewed by the Disability Services Coordinator (DSC) who will verify the disability as to the reliability of the request. The DSC will then notify the student if they are eligible for accommodations.

I. Student Information: (Please Print Legibly or Type)

BYUH ID #:

Student's Name

First:

Middle:

Sur/Last:

Date of Birth:

Student's Current Address:

Street:

City: State: Zip:

Phone:

Email:

II. Provider Section:

1. Contact with Student

a. Date of initial contact with student: ☐

b. Date of last contact with student: ☐

2. Diagnosis

a. Clinical History:

i. Does the student have a clinical history of ASD symptoms?

Yes ☐ No ☐

ii. Approximately at what age did the student start to exhibit ASD symptoms? ☐

iii. At approximately what age was the student diagnosed with ASD? ☐

b. Current Symptoms:

i. Please provide information regarding the student's current presenting symptoms with regard to the following:

social interaction, reciprocal verbal communication, shared emotions and affect	
nonverbal communication	
restricted, repetitive patterns of motor behavior, stereotypies	
inflexible adherence to routines	
hyper or hypo-reactivity to sensory input	

ii. What is the severity of the disorder with regard to social communication impairments and restricted, repetitive patterns of behavior, based on the ***DSM-5*** 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)	

iii. Is there clear evidence that the student's ASD symptoms are interfering with or reducing the quality of functioning in at least one area? Describe how the impairment interferes with functioning.

Academic functioning:	
Social functioning:	
Work functioning:	

iv. 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 ☐

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

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

c. 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)*.

i. Is this information contained within an accompanying evaluative report? Yes ☐ No ☐

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.

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

d. ***DSM-5* Codes**:

Please include all pertinent diagnoses or rule-out diagnoses using *DSM-5* codes.

Principal Diagnosis: _____

Code: _____

Severity or Level of Impairment: _____

Descriptive Features: _____

Course: _____

Other Diagnoses: _____

Code: _____

Severity or Level of Impairment: _____

Descriptive Features: _____

Course: _____

WHODAS 2 Score (If given): _____

1. Medications

a. Is the student currently taking medication(s) for ASD symptoms? Yes ☐ No ☐

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

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.):	

2.Functional Limitations and Recommended Accommodations

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

Symptom:
Recommended Reasonable Accommodation(s):

Symptom:
Recommended Reasonable Accommodation(s):

II. Provider's Certifying Professional Information:

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, or neuropsychologist). The provider signing this form must be the same person answering the above questions.

***Note**: For ethical reasons, documentation from a family member or relative cannot be accepted, even if they are licensed.

Provider's Name: (International Providers, please fill out as much information as possible about your qualifications)

First:

Middle:

Last:

Credentials:

License Number*:

State of Licensure:

Street Address:

City:

State:

Zip:

Phone #:

Email Address:

Stamp Here (unless provider is from BYUH):

Signature of Provider: Date:

** ***I authorize BYU–Hawaii to receive information from the healthcare provider above. I also authorize my healthcare provider to discuss relevant information as to my condition(s) with the appropriate and qualified BYU–Hawaii personnel on an as-needed basis.***

Signature of Student: Date:

Submitting this Form:

This form may be returned to the student or submitted directly to the Disability Services Office at BYU–Hawaii. Information regarding BYU–Hawaii's Disability Services Office can be found at: https://disability.byuh.edu/. If you have any additional questions, you may contact disabilityservices@byuh.edu or 808-675-3518. Thank you for assisting BYU–Hawaii in this accommodation process.