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

VERIFICATION FORM for ATTENTION DEFICIT / HYPERACTIVITY DISORDER (AD/HD)

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 AD/HD 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 AD/HD.

A summary of the guideline criteria for documenting AD/HD is listed below.

1. Clinical history of AD/HD
2. Symptoms of inattentiveness and/or impulsivity and hyperactivity determined through the administration of measurements of attention and/or AD/HD rating scales or checklists
3. Functional impairment in one or more settings, including educational
4. Functional limitations affecting an important life skill, including academic functioning
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 Section: (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 (i.e., prior to age 12) of AD/HD symptoms?

Yes ☐ No ☐

ii. Approximately at what age did the student start to exhibit AD/HD symptoms? ☐

iii. What date was the student diagnosed with AD/HD? Month ☐ Year ☐

b. Current Symptoms:

i. Please check all AD/HD symptoms that the student currently exhibits:

Inattention: *(5+ checked for adolescents 17 and older indicates functional impairment)*	
	Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.
	Often has difficulty sustaining attention in tasks or play activities.
	Often does not seem to listen when spoken to directly.
	Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., loses focus, side-tracked).
	Often has difficulty organizing tasks and activities.
	Often avoids, dislikes, or is reluctant to engage in tasks (such as schoolwork or homework) that require sustained mental effort.
	Often loses things necessary for tasks or activities (e.g., school assignments, pencils, books, tools, wallets, keys, paperwork, eyeglasses, cell phone).
	Is often easily distracted by extraneous stimuli.
	Is often forgetful in daily activities.

Hyperactivity and Impulsivity: *(5+ checked in Hyperactivity and Impulsivity categories combined for adolescents 17 and older indicates functional impairment)*	
	Often fidgets with or taps hands or feet, or squirms in seat.
	Often leaves (or greatly feels the need to leave) seat in classroom or in other situations in which remaining seated is expected.
	Often runs about or climbs excessively in situations in which it is inappropriate (adolescents or adults may be limited to feeling restless).
	Often unable to play or take part in leisure activities quietly.
	Is often “on the go” or often acts as if “driven by a motor.”
	Often talks excessively.
	Often blurts out answers before questions have been completed.
	Often has difficulty awaiting turn.
	Often interrupts or intrudes on others (e.g., butts into conversations or games).

ii. Is there clear evidence that the student's AD/HD symptoms are present in one or more setting, including the educational environment? Describe how the impairment interferes with functioning.

School (classroom or educational setting):	
Home or work:	
With friends or relatives:	
In other activities:	

iii. Is there clear evidence that the student's AD/HD symptoms are interfering with or reducingthe quality of at least one of the following, including academic functioning? Describe how the impairment interferes with functioning.

Academic functioning:	
Social functioning:	
Work functioning:	

iv. Did you use a measurement of AD/HD, e.g. rating scale, checklist, psychological evaluation, performance task, to obtain information about the student's symptoms and functioning in various settings?

Yes ☐ No ☐

v. If yes, which AD/HD measurement did you use?

vi. If no, how did you reach your conclusion about the AD/HD diagnosis and treatment?

c. ***DSM-5* Codes**:

i. 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): _____

3. Medications

a. Is the student currently taking medication(s) for AD/HD 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.):	

*Use the back if necessary.

4. Functional Limitations and Recommended Accommodations

a. Please list the student's current AD/HD symptoms and indicate what ***reasonable academic accommodations*** would mitigate the symptom listed.

Symptom:
Recommended Reasonable Accommodation(s):

Symptom:
Recommended Reasonable Accommodation(s):

Symptom:
Recommended Reasonable Accommodation(s):

*Use the back, if necessary

III. 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 Licenser:

Street Address:

City:

State:

Zip:

Phone Number:

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.