Autism Spectrum Disorder Documentation Instructions and Documentation Submission Form

Student Instructions and Information:

1. Students must submit medical documentation of Autism Spectrum Disorder from a qualified provider (medical doctor or psychiatrist) to the Access & Accommodations Center (AACE). You may do so by having your qualified provider complete this Form or by submitting a letter from a qualified provider that includes all of the information requested in this form. Letters from qualified providers must be on letterhead from the provider's practice and must include the provider's signature and credentials.
2. Documentation of Autism Spectrum Disorder must be **current**. Less recent documentation may be submitted for review, but may not be accepted if it fails to adequately indicate current functioning. The Board of Regents guidelines define current as less than 3-5 years old.
3. Students should submit the required medical documentation **prior to the initial meeting with AACE** since appropriate accommodations are discussed at that time.
4. How often medical documentation must be updated will be determined by AACE based on the student's individual situation.
5. Documentation may be submitted through the AIM portal at https://access.gsu.edu/

To be Completed by Student:

Name (Last, First, Middle):_____

Date of Birth:_____ GSU ID:_____

Cell Phone:_____Alternate Phone: _____

Home Address: _____

_____

Email Address: _____

Status (Check One):_____Current Student _____Transfer Student _____Prospective Student

To be Completed by Provider:

To establish eligibility for accommodations under the ADA, students must submit current and comprehensive medical documentation from a qualified provider for any diagnosis of a disability. The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities.

Please check all of the following DSM-5 diagnostic criteria as appropriate to describe current symptoms. **Attach standardized assessments (e.g. Autism Diagnostic Observation System, Autism Diagnostic Interview-Revised, Social Communications Questionnaire) as appropriate.**

_____Persistent deficits in social communication and social interactions across multiple contexts, such as deficits in:

- _____Social-emotional reciprocity
- _____Nonverbal communicative behaviors used for social interaction
- _____Developing, maintaining, and understanding relationships

_____Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of thefollowing:

- _____Stereotyped or repetitive motor movements, use of objects, or speech
- _____Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal/nonverbal behavior
- _____Highly restricted, fixated interests that are abnormal in intensity or focus
- _____Hyper- or hypo reactivity to sensory input or unusual interests in sensory aspects of the environment

Please indicate the severity level of the disorder as appropriate.

_____Level 1: Requiring support
_____Level 2: Requiring substantial support
_____Level 3: Requiring very substantial support

Please describe the history of the disorder, specifically the above listed symptoms present in early childhood.

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Please check all of the following as appropriate to describe the patient's functional limitations.

_____Poor concentration
_____Distracted by internal stimuli

_____Disorganized
_____Difficulty letting go of ideas, accepting alternate ideas
_____Difficulty communicating with faculty/staff and/or other students
_____Struggles with making friends and fitting in with peers
_____Difficulty taking responsibility for own learning and completing tasks according to timetables
_____Trouble living with others, need for quiet and solitude in order to work and study
_____Problems interacting with others in seminars or groups
_____Difficulty speaking in public
_____High levels of anxiety and vulnerability to stress
_____Poor time management
_____Problems in learning by observation
_____Difficulties with ambiguous instructions
_____Other_____
_____

_____Other_____
_____

_____Other_____
_____

Please provide any additional information/context as appropriate concerning the functional limitations.

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Please provide any recommendations to address the indicated functional limitations.

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Please attach any psychological and/or educational reports that support the diagnosis and complete the following information:

PLEASE NOTE: Assessment of broad cognitive ability using standardized assessment measures with age appropriate norms (e.g. WAIS-IV, DAS, RIAS, C-TONI) is required.

ATTENTION PROVIDER: By signing below you are verifying that the individual has been diagnosed with Autism Spectrum Disorder (DSM-5 Code F84.0). Specify if:

_____With accompanying intellectual impairment
_____With accompanying language impairment
_____Associated with a known medical or genetic or environmental factor

Please complete the following information:

Provider Name: _____

Title: _____

License #: _____

Practice Name and Address: _____

Phone: _____Fax: _____

Email: _____

Provider Signature **(Wet Signature Required)**: _____

Date of Signature: _____