Bucks County Community College

Verification Form

Autism Spectrum Disorder (ASD)

Bucks County Community College's Accessibility Office (TAO) has established the Verification Form for Autism Spectrum Disorder (ASD) to obtain current information from a qualified practitioner (e.g., physician, psychiatrist, psychologist) regarding a student's ASD symptoms, related medications, and their impact on the student and his or her need for accommodations in the higher education classroom setting. 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 Bucks County Community College's TAO guidelines for ASD. **The person completing this form may not be a relative of the student or hold power of attorney over the student.**

A summary of the guideline criteria for documenting ASD can be found at the following web site: http://www.bucks.edu/student/accessibility/student-info/. A summary of the guideline criteria for documenting ASD is as follows:

1. A 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 and
6. Summary and recommendations

Section I: Student Information (Please type information or print legibly)

Student Name: _____
Last First Middle

Student ID: _____ **Date of Birth:** _____

Cell Phone: _____ **Home Phone:** _____

Bucks Email: _____ **Home Email:** _____

Permanent Street Address: _____

_____

City: _____ **State:** _____ **Zip:** _____

Local Street Address: _____

_____

City: _____ **State:** _____ **Zip:** _____

Section II: Provider Section (Please type information or print legibly)

A. Contact with the Student:

Date of initial contact with the student: _____

Date of last contact with the student: _____

B. Diagnosis Information:

1. Clinical History

Does the student have a clinical history (i.e., prior to age 12) of ASD symptoms? ☐ **Yes** ☐ **NO**

Approximately at what age did the student start to exhibit ASD symptoms? _____

What date was the student diagnosed with ASD symptoms? _____ _____
Month Year

2. Current Symptoms

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

Presenting Symptoms	
Social interaction and/or Nonverbal communication:	
Sensitivity to sensory input:	
Fixated interests:	
Repetitive behaviors and / or Adherence to routines:	

b. What is the severity of the disorder with regard to social impairments and rituals and repetitive behaviors 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)	

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

Environmental Functioning:	
School functioning:	
Social functioning:	
Work functioning:	

d. Did you use an autism-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**

1) If yes, which ASD behavioral evaluation and/or Rating Scale(s) or Checklist(s) did you use?

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

e. 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).

1) Is this information contained within an accompanying evaluative report? ☐ **Yes** ☐ **NO**

Aptitude:
List the name of the comprehensive and current aptitude/cognitive instrument administered
List the standard scores per subtest; and (c) the percentiles per subtest

Achievement:
List the name of the comprehensive and current achievement battery administered
List the standard scores per academic area subtest
List the percentiles per academic area subtest

3. **DSM Codes:** Please include all pertinent diagnoses or rule-out diagnoses using DSM codes.

Please include all pertinent diagnoses or rule-out diagnoses using DSM codes.	
Axis I:	
Axis II:	
Axis III:	
Axis IV:	
Axis V (GAF):	

C. Medications:

1. Is the student currently taking medication(s) for ASD symptoms? ☐ **Yes** ☐ **NO**
2. If yes, please provide information below for each medication the student is currently prescribed:

Medication • Dosage • Frequency (e.g., Adderall 5 mg 1 x daily):	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication • Dosage • Frequency (e.g., Adderall 5 mg 1 x daily):	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication • Dosage • Frequency (e.g., Adderall 5 mg 1 x daily):	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

D. Functional Limitations and Recommended Accommodations:

1. Please list the student's current ASD symptoms and then indicate what reasonable academic accommodations would mitigate the symptom listed.
2. **Sample:** Student may have difficulty tolerating distractions during exams and would benefit from a distraction-reduced environment to take tests.

Symptom: (Example)
Difficulty tolerating distractions (i.e., low tolerance for noise)
Recommended Reasonable Accommodation(s):
Student should be provided a testing environment that limits distractions during tests, exams or quizzes.

Symptom:
Recommended Reasonable Accommodation(s):

Symptom:
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Symptom:
Recommended Reasonable Accommodation(s):

Symptom:
Recommended Reasonable Accommodation(s):

Symptom:
Recommended Reasonable Accommodation(s):

Section III: Provider's Certifying Professional Information:

(Please type information or print legibly)

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

Provider's Name: _____
Last First Middle

Credentials: _____

License Number: _____ **State of Licenser:** _____

Phone Number: _____ **Email:** _____

Practice Street Address: _____

_____

City: _____ **State:** _____ **Zip:** _____

May this completed Verification Form be released to the student? ☐ **Yes** ☐ **NO**

Provider Signature: _____ **Date:** _____

Section IV: Submitting this Form

This form should be returned to the Accessibility Office (TAO) at Bucks County Community College where the student is enrolled. All forms need to be submitted at the Newtown campus. Please see the following methods of submission of this form:

Email: accessibility@bucks.edu

Fax: (215) 968-8033

USPS: Bucks County Community College
Attention: The Accessibility Office
275 Swamp Road
Newtown, Pennsylvania 18940

Physical Drop Off: Newtown Campus
Rollins Center • Student Services Office • Room 001

Information regarding the Accessibility Office (TAO) at Bucks County Community College can be found at http://www.bucks.edu/student/accessibility/. Please visit our website for the latest information and updates as they are made available. If you have any questions, please feel free to call us (215) 968-8182.