Autism Spectrum Documentation Form

Student Name: _____________________________ DOB: _____ / _____ / ____ has requested support services from the Office of Disability Services for Students (DSS) at Indiana University Bloomington (IUB) in regards to an autism spectrum disorder. Documentation provides vital information about the functional limitation of the student’s disability and its impact in a post-secondary academic environment.

Please complete all sections of this form and return it as soon as possible so that we may verify the student’s eligibility for services. Providers may also use their own format as long as the information requested below is included; if this information is not provided, services may be delayed as DSS obtains clarification. Please call 812-855-7578 if you have questions. The completed form may be faxed to 812-855-7650 or it may be mailed to the address at the bottom of this page. DSS welcomes any additional documentation you would like to include.

DSM-V Diagnoses (Please provide both code and descriptor): (REQUIRED)
Primary: ____________________________________________________________
Secondary: ____________________________________________________________

Date of Diagnosis: _____ / _____ / ____ Initial visit: _____ / _____ / ____ Last appointment: _____ / _____ / ____

Basis on which Diagnosis was made (check all that apply):

- □ Psycho-educational or neuropsychological assessment (please attach report)
- □ Psychological Assessment (please attach report)
- □ Standardized rating scales (please attach report)
- □ Structured or unstructured interviews with student
- □ Structured or unstructured interviews with other relevant persons (e.g. parent, therapist, teacher)
- □ Behavioral observations
- □ Developmental history
- □ Medical history
- □ Other (Please specify):


Clinical Manifestations/Symptoms: Please provide information regarding the student’s current presenting symptoms with regard to the following:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Information</th>
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<tbody>
<tr>
<td>Social interaction, reciprocal verbal communication, shared emotions</td>
<td></td>
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<tr>
<td>and affect</td>
<td></td>
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<tr>
<td>Nonverbal communication</td>
<td></td>
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<tr>
<td>Restricted, repetitive or unusual patterns of motor behavior. i.e.</td>
<td></td>
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<tr>
<td>stereotypic</td>
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<tr>
<td>Adherence to routines</td>
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</table>
Hyper or hypo reactivity to sensory input

Executive Function

| Implications for Educational Success/Major Life Activities (REQUIRED): |
|-----------------|-----------------|-----------------|
| Please check which of the major life activities listed below are affected because of the diagnosis. |
| *Substantial limitation is defined as a “significant restriction in the condition, manner, or duration in which a major life activity is performed compared to most people.”* |

- [ ] Concentration *
- [ ] Memory *
- [ ] Cognitive functioning *
- [ ] Processing speed *
- [ ] Communication
- [ ] Complex/abstract thinking
- [ ] Making and keeping appointments
- [ ] Managing external distraction
- [ ] Managing internal distraction
- [ ] Meeting deadlines
- [ ] Motor skills: _____________
- [ ] Stress management
- [ ] Task persistence
- [ ] Task organization/ prioritization
- [ ] Time management
- [ ] Other: ________________
- [ ] Other: ________________

*Note: Appropriate psychometric data must be included for these areas of limitation.

Prescribed medication and the side effects that impact academic functioning:

__________________________________________

Additional comments and recommended auxiliary support, strategies, or service that may be beneficial to the student in the higher education environment.

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

Certifying Professional

Name (print): ____________________________________________ Date: _____ / _____ / _____

Profession: ____________________________________________ License number: _____________________

Office Address: _____________________________________________________________________________

Phone: __________________ Fax: __________________________ Email Address: _____________________

Certifying Professional Signature: ___________________________________________________________