

Student Ability Success Center San Diego State University

Documentation Guidelines for AD/HD

In order to determine eligibility for accommodations and services from Student Ability Success Center (SASC) at San Diego State University, verification and supporting documentation of the student's disability must clearly demonstrate that he or she meets the definition of disability as stated in the ADA Amendments Act of 2008 (ADAAA). The impairment must substantially limit one or more major life activities and affect the student's ability to function in an academic environment.

Before receiving services, each student seeking accommodations and services from SASC must have a comprehensive evaluation on file, which demonstrates impaired attention and/or hyperactivity/impulsivity. The disability must be verified by a licensed professional who has expertise in the differential diagnosis of AD/HD and with direct experience with an adult population. If possible, a psycho-educational evaluation should be provided, since it will be useful in determining the current impact of the AD/HD on academic functioning. If provided, it must include an assessment of aptitude as well as academic achievement with all subtests and scores reported.

Documentation of disability must include:

1. Clinician's name, title, license number, phone number and address, and date(s) of examination.
2. A summary of educational, medical, family histories and behavioral observations, which substantiates a diagnosis of AD/HD.
3. Prior assessment to determine a history of attention problems if it established the diagnosis, with a statement of how the disorder substantially interferes with the student's educational progress.
4. If applicable, information relating to current medication used to treat AD/HD and the impact (if any) of the medication on the student's ability to meet academic demands.
5. A clear statement of the DSM-IV diagnosis and instruments used in making the diagnosis. Alternative diagnoses and medical or psychological disorders with behaviors that appear similar to AD/HD must be ruled out.

Recommended instruments to be used are:

- **Aptitude:** Wechsler Adult Intelligence Scale (WAIS-III or WAIS-IV) or Woodcock Johnson-III (WJ-III) Tests of Cognitive Ability-extended.
- **Achievement:** Wechsler Individual Achievement Test-III (WIAT - III) or Woodcock Johnson-IV (WJ-IV) Tests of Achievement and Nelson Denny Reading Tests (optional).

Requests for accommodations are considered on a case-by-case basis and the determination of actual services and accommodations will be made by the Student Ability Success Center.

Disability Verification (AD/HD)

The student named below may be eligible for services and accommodations offered through the Student Ability Success Center at San Diego State University. In order to determine eligibility, verification and documentation of the student's disability must clearly demonstrate that he or she has one or more functional limitations in the academic environment. Please note that the determination of actual services and accommodations will be made by the Student Ability Success Center.

TO BE COMPLETED BY STUDENT (Please type or print legibly in ink):

Last Name: _____ First Name: _____

Red ID#: _____ Date of Birth: _____

I authorize the release of the information requested below to the Student Ability Success Center at San Diego State University.

Student's Signature: _____ Date: _____

TO BE COMPLETED BY A LICENSED PROFESSIONAL:

1. Diagnosis:

2. Multiaxial DSM IV Classification(s):

3. The disability is:

permanent

temporary and expected to last through _____

4. Level of severity:

Mild

Moderate

Severe

5. Date of first office visit:

6. Date of last office visit:

6. Date(s) of diagnosis:

7. Assessment/evaluation procedures. Attach scores of all tests administered. If available, please include a psychoeducational report.

8. Please check all AD/HD symptoms that the student currently exhibits. Reprinted with permission from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, (Copyright 2000). American Psychiatric Association.

Diagnostic Criteria for Attention-Deficit/Hyperactivity Disorder

(A) Either (1) or (2):

(1) six (or more) of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level;

INATTENTION

| | |
|--------------------------|---|
| <input type="checkbox"/> | Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities |
| <input type="checkbox"/> | Often has difficulty sustaining attention in tasks or play activities |
| <input type="checkbox"/> | Often does not seem to listen when spoken to directly |
| <input type="checkbox"/> | Often does not follow through on instructions and details to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions) |
| <input type="checkbox"/> | Often has difficulty organizing tasks and activities |
| <input type="checkbox"/> | Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework) |
| <input type="checkbox"/> | Often loses things necessary for tasks or activities (e.g. school assignments, pencils, books, tools, etc.) |
| <input type="checkbox"/> | Is often easily distracted by extraneous stimuli |
| <input type="checkbox"/> | Is often forgetful in daily activities |

(2) six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

HYPERACTIVITY

| | |
|--------------------------|---|
| <input type="checkbox"/> | Often fidgets with hands or feet or squirms in seat |
| <input type="checkbox"/> | Often leaves seat in classroom or in other situations in which remaining seated is expected |
| <input type="checkbox"/> | Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness) |
| <input type="checkbox"/> | Often has difficulty playing or engaging in leisure activities quietly |
| <input type="checkbox"/> | Is often "on the go" or often acts as if "driven by a motor" |
| <input type="checkbox"/> | Often talks excessively |

IMPULSIVITY

| | |
|--------------------------|---|
| <input type="checkbox"/> | Often blurts out answers before questions have been completed |
| <input type="checkbox"/> | Often has difficulty awaiting turn |
| <input type="checkbox"/> | Often interrupts or intrudes on others (e.g. butts into conversations or games) |

(B) Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.

(C) Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).

(D) There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

(E) The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or Personality Disorder).

9. Relevant background information (student's history related to disability):

10. How does the student's disability affect his/her ability to function in an academic environment? (e.g., mobility, classroom activities, memory, perception, processing speed, etc.)

11. Current prescribed medications related to disability:

| Medication | Dose/Frequency | Effects/Side Effects |
|------------|----------------|----------------------|
|------------|----------------|----------------------|

| | | |
|-------|-------|-------|
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I certify that the above referenced client/patient has a "physical or mental impairment that substantially limits one or more of the major life activities of such individual" as defined by the ADA Amendments Act of 2008 (ADAAA). In addition, I have the necessary professional qualifications to document my client/patient's disability, and the information provided on this form is accurate to the best of my knowledge.

Name of Professional (PLEASE PRINT): _____

Signature of Professional: _____

License#: _____ Date: _____

Address: _____

Phone#: _____ Fax#: _____

Return this form to our office as soon as possible so this student may begin participation in our program. Please include any verifying documents from your files.

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