



Verification of ADHD/Learning Disability or Psychological Conditions

The Learning Assistance Center at the Art Academy of Cincinnati provides services and/or accommodations for students with disabilities intended to facilitate equal access to education opportunities. To determine eligibility for services and/or accommodations, current and comprehensive documentation regarding a physical or mental condition and its impact on the student's functioning is required from a licensed medical professional qualified to diagnose and treat the particular condition(s).

I request that this form be completed and returned along with any supporting documentation regarding my condition, to the Office of Counseling/Learning Assistance.

Signature _____ Date _____

*Please see bottom of last page of form for Office of Counseling? Learning Assistance contact information.

Please complete the following:

Name of Student: _____ Date of Birth _____

Date of Diagnosis: _____ Date of last contact _____

What sources were used to obtain information that verified a diagnosis? Check all that apply.

- History of presenting symptoms.
- Academic history of elementary, secondary, tertiary education. Attach any supporting documentation, e.g. Individualized Education Plan (IEP), 504 Plan, Multi-Factored Evaluation (MFE), teacher reports, etc.
- Family History. Prevalence in the family of same or other related diagnosis.
- Medical/ medication history
- History of previous therapy that is relevant to the current diagnosis.

Were any instruments or psychometric procedures used in confirming the diagnosis? Check all that apply. Please indicate date of testing and instrument(s) used.

- Neuropsychological testing Date: _____
- Psycho-educational testing Date: _____
- Rating scales Date: _____
- Checklists Date: _____
- Other (please specify) _____

DSM –IV diagnosis

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: (GAF Score): _____

What is the anticipated duration of the impacting symptoms?

Please Circle one: 6 months 1 year more than 1 year

Please explain duration:

Major Life Activities Impacted

Below is a checklist of the major life activities that could be impacted by a diagnosis of ADHD and/or PC. Please check all that apply, indicating the severity of impact.

Major Life Activity	No Impact	Mild Impact	Moderate Impact	Substantial Impact
Caring for one's self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing internal distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing external distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Interactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organizing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Regularly and timely attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making and keeping appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maintaining deadlines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How else might the student's symptoms impact his/her academic performance?

Please list any current medication, dosage, frequency, and side effects that may affect the student's academic performance:

What are your recommendations for reasonable accommodations? Please provide a rationale based upon the functional limitations of this student in an academic setting.

HEALTHCARE PROVIDER INFORMATION

Signature: _____	Date: _____
Print Name and Title: _____	
License Number: _____	
Address: _____	
Phone: _____	

Return this information to:
Art Academy of Cincinnati
Office of Counseling/ Learning Assistance Services
1212 Jackson Street, Room S554
Cincinnati, Ohio 45202
Phone: (513) 562-8759 Fax: (513) 562-8778