Sarah Lawrence College

Documentation of Attention-Deficit/Hyperactivity Disorder (AD/HD)

A student at Sarah Lawrence College (SLC) is requesting accommodations under the Americans with Disabilities Act on the basis of Attention-Deficit/Hyperactivity Disorder (AD/HD). This office requires current and comprehensive documentation of the student's disorder from a qualified evaluator. The following professionals generally would be considered qualified to evaluate and diagnose AD/HD: licensed psychologists, psychiatrists neuropsychologists, and other relevantly trained medical doctors. T**he provider completing this form cannot be a relative of the student**. Specific information concerning the student's condition and its impact on learning must be provided. **Please fill out the form completely.** Any questions should be directed to the Office of Access and Disability Services at disabilityservices@sarahlawrence.edu.

_____

For the student to complete:

NAME (please print): _____ SLC ID: _____

For the healthcare provider to complete **(Please print legibly or type)**:

1. Please list the ICD-10 or DSM-5 Diagnosis (text and code):

Diagnosis: _____

a. State the student's current symptoms that meet the criteria for the diagnosis. _____

_____

_____

b. What is the current severity of the condition? _____

c. Date of your last clinical contact with student: _____

d. What are the frequency of your appointments? _____

e. State the age of onset of symptoms described in DSM-5 or ICD-10: _____

3. How did you diagnose AD/HD? Please check all that are relevant.

- ☐ Structured or unstructured interviews with student
- ☐ Interviews with other people (parent, therapist, doctor, teacher)
- ☐ Behavioral observations
- ☐ Psychoeducational testing (please attach report)
- ☐ Neuropsychological testing (please attach report)
- ☐ Developmental history
- ☐ Other: _____
- ☐ Notes:_____

_____

_____

4. Describe in detail the symptoms related to the student's condition that cause *significant* impairment in a major life activity.

_____

_____

_____

_____

_____

5. List the student's current medication(s), dosage, frequency, and any adverse side effects.

_____

_____

a. Are there significant limitations to the student's functioning directly related to the prescribed medications? YES _____ NO _____

b. If YES, please describe. _____

_____

_____

6. Are there any coexisting psychiatric conditions? [ ] Yes [ ] No

If yes, please list all ICD-10 or DSM-5 diagnoses (text and code).____

_____

_____

7. Please state specific recommendations regarding academic accommodations for this student, and a rationale as to why these accommodations are warranted based upon the student's functional limitations.

Accommodation	**Rationale**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____

Provider Information:

License #: _____ State: _____

Name and Title (please print): _____

Address:_____

Email: _____

Phone: _____ Fax: _____

Signature of Provider: _____ Date: _____

ALL DOCUMENTATION WILL BE HELD IN THE STRICTEST CONFIDENCE

THANK YOU FOR YOUR ASSISTANCE IN PROVIDING THIS INFORMATION.

IF YOU HAVE QUESTIONS PLEASE EMAIL: disabilityservices@sarahlawrence.edu

Please returned this signed form to: The Office of Access and Disability Services
disabilityservices@sarahlawrence.edu