

CERTIFICATION OF ADHD DISORDERS

The student named below has applied for services from the Student Disability Resource Center (SDRC) at UC Riverside. In order to determine eligibility and to provide services, we require documentation of the student's disability and specific impairments from a reliable source in order to conduct an individualized assessment of accommodation needs. Under the Americans with Disabilities Act as Amended (ADAAA) of 2008 and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. To establish that an individual is covered under the law, documentation must indicate that a specific disability exists and that the identified disability substantially limits one or more major life activities. A diagnosis of a disorder in and of itself does not automatically qualify an individual for accommodations. The documentation must support the requested accommodations.

Please return completed form to sdruc@ucr.edu. The information you provide will *not* become part of the student's academic records, but will be kept in the student's file at SDRC, where it will be held in accordance with federal laws regulating privacy of student records. This form may be released to the student at their request. In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment. Please contact us if you have questions or concerns. Thank you for your assistance.

STUDENT (please sign this form before providing it to your mental health care provider to complete):

By signing below, I consent to allowing my health care provider to share any information relevant to my need for disability related accommodations, as shown on this form, with (personnel from the SDRC office) for the next 60 days.

Student Name (Print) _____ (signature) _____ Date _____
 Student UCR email: _____

TO BE COMPLETED BY THE LICENSED PROVIDER (incomplete information may nullify this request):

Patient Name: _____ Today's Date: _____
 Initial Date of Diagnosis (below): _____ Date of most recent appt: _____
 Dates of treatment within the last 6 months for the above diagnosis: _____

**What is the nature of the student's neurodevelopmental ADHD impairment?
 DSM-V DIAGNOSIS (include DSM V or ICD 10 Codes, include subtypes and specifies)**

DSM-V DIAGNOSIS (include DSM V or ICD 10 Codes, include subtypes and specifies)

- | | |
|--|---|
| <input type="checkbox"/> 314.00 (F90.0) Predominantly inattentive presentation | <input type="checkbox"/> 314.01 (F90.2) Combined presentation |
| <input type="checkbox"/> 314.01 (F90.1) Predominantly hyperactive-impulsive presentation | <input type="checkbox"/> 314.01 (F90.8) Other Specified ADHD |
| <input type="checkbox"/> The student does not meet diagnostic criteria for ADHD | <input type="checkbox"/> 314.01 (F90.9) Unspecified ADHD |

Other Diagnosis: _____
 Other Diagnosis: _____
 Other Diagnosis: _____

1. In addition to DSM-V criteria, how did you arrive at your diagnosis? Please check all relevant items below, **adding brief notes that you think might be helpful to us as we determine which accommodations and services are appropriate for the student.**
Please submit recent Neuropsych testing to SDRC with this form.

Check Assessment or Evaluation Procedure use to Make Diagnosis		
<input type="checkbox"/> Neuropsychological testing: Report Attached	<input type="checkbox"/> Structured interviews with the student	<input type="checkbox"/> Developmental history
<input type="checkbox"/> Psychoeducational testing: Report Attached	<input type="checkbox"/> Unstructured interviews with the student	<input type="checkbox"/> Reviewed Medical history
<input type="checkbox"/> Standardized/non-standardized Rating scales: Report Attached	<input type="checkbox"/> Interviews with other persons	<input type="checkbox"/> Behavioral observations
<input type="checkbox"/> Other (please specify): _____		

1. Treatment Plan: How often will you be seeing the student for treatment of this diagnosis?
 No f/u appointments scheduled Specify frequency: _____
2. What medications have you prescribed the student?
 N/A, I do not prescribe medication; This patient is not taking medication; This patient has been referred to Rx therapy
 List Side effects: No Known Side Effects; or _____

Effectiveness of Medication(s): Very Effective Moderately Effective Somewhat Effective Unknown

3. Please check which of the major life activities below are affected because of the neuro/developmental diagnosis. Please indicate the level of limitation.

Life Activity	No Impact	Mild Impact	Moderate Impact	Severe Impact	Don't Know
Sustained Attention / Focus					
Attentiveness (attention to details)					
Managing internal distractions (thoughts / ruminations)					
Managing external distractions					
Organization / Planning / Prioritizing / Execution of plans					
Memory: using working memory and accessing recall					
Fidgets with or taps hands, feet, or squirms in seat					
Internal restlessness					
Motivation (identifying reasons to act)					
Processes information by talking to themselves (aloud)					
Initiation / activation (difficulty getting started)					
Fine motor skills/ writing/ penmanship					
Perseveration / Making Decisions					
Distress Tolerance (overwhelmed easily)					
Impulsive					
Visual Tracking					
Auditory Processing					
Emotional regulation: managing frustration & modulating emotions					
Being still for a prolonged period of time (...while taking an exam)					
Setting and working on long-term goals					
Estimating time to complete and submit assignments					
Social interactions					
<input type="checkbox"/> Insomnia / <input type="checkbox"/> Hypersomnia					

4. What other specific symptoms are manifesting themselves at this time that might affect the student's academic performance?

5. What is the student's prognosis? How long do you anticipate that the student's academic achievement will be impacted by the current symptoms?

Check One: 3 months or less ≈ 6 months ≈ 1 year Permanent/Chronic Unknown

6. Is there anything else you think we should know about the student's disability (e.g., frequency of appointments)?

CERTIFYING LICENSED PROFESSIONAL *

*I certify, by my signature, that I conducted or formally supervised and co-signed the diagnostic assessment of the individual named above. In cases where the diagnostic assessment of the individual was performed by another clinician, my signature confirms the review of the original assessment and agreement of the diagnosis. The diagnosing/treating professional must have expertise in the differential diagnosis of the documented neurological disorder(s) and follow established practices in the field. **This form may not be completed by a family member.**

Printed Name: _____ Signature: _____

License Number: _____

Neurologist Psychologist Psychiatrist Primary Care Physician Other: _____

Name of Practice: _____ website: _____ Phone: _____

Address: _____ City _____ State _____ Zip _____

* Professionals conducting assessments, rendering diagnoses of neuro/cognitive origins, and making recommendations for accommodations must be qualified and licensed to do so. Comprehensive training and relevant experience in differential diagnosis and the full range of neuro/cognitive and mental disorders are essential, specifically the various subtypes of ADHD. In accordance with professional ethics, **this form may not be completed by a family member.** Practitioners who function under a supervising physician / mental health professional license (e.g., PA, NP, Nurse, Psych intern, MFTI,...), must have this form signed by the licensed professional supervising their work. Incomplete forms may delay services.