UC RIVERSIDE | Student Disability Resource Center

900 University Ave.
1228 Student Services Build.,
Riverside, CA 92521
P (951) 827-3861
https://sdrc.ucr.edu/
Submit completed from to sdrc@ucr.edu

CERTIFICATION OF NEUROLOGICAL DISORDERS

(Traumatic Brain Injuries, Seizure D/O, Communications D/O, Autism Spectrum, Motor, Other Neurological or Developmental Disorders)
DO NOT USE THIS FORM FOR Learning Disorders or ADHD

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 Autism Spectrum Disorder. 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 sdrc@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 neuro/developmental health impairment?
DSM-V DIAGNOSIS (include DSM V or ICD 10 Codes, include subtypes and specifies)

Principle Diagnosis: _____

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		
☐Neuropsychological testing: Report Attached	☐Structured interviews with the student	☐Developmental history
☐Psychoeducational testing: Report Attached	☐Unstructured interviews with the student	☐Reviewed Medical history
☐Standardized/non-standardized Rating scales: Report Attached	☐Interviews with other persons	☐Behavioral observations ☐Educational history
☐Other (please specify):		

1. Is the patient/student subject to flare-ups? ☐No ☐Yes; Please provide information on frequency, intensity, and duration of impact?

2. Treatment Plan: How often will you be seeing the student for treatment of this diagnosis?
☐ No f/u appointments scheduled ☐ Specify frequency:_____

3. What medications have you prescribed the student? ☐N/A, I do not prescribe medication.
List Side effects: ☐No Known Side Effects; or ☐ _____
Effectiveness of Medication(s): ☐ Very Effective ☐ Moderately Effective ☐ Somewhat Effective ☐Unknown

4. 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					
Concentration / Focus					
Managing internal or external distractions					
Information Processing					
Organization / Planning / Prioritizing					
Memory: using working memory and accessing recall					
Motivation or Initiation					
Task Switching					
Perseveration / Making Decisions					
Distress Tolerance (overwhelmed easily)					
Impulsive					
Visual Tracking					
Auditory Processing					
Regulation of Emotions					
Speech Production					
Pragmatic Communication					
Estimating time to complete and submit assignments					
Stamina / Fatigue					
Walking/ Ambulation					
☐ Balance / ☐ Coordination					
Performing Manual tasks (which hand? ☐ L / ☐ R)					
☐ Insomnia / ☐ Hypersomnia					
Use of Mobility Device					
Other:					

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

6. 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**

7. 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:_____

Address: _____City_____State_____Zip_____

Telephone: _____Fax: _____

* 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. 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.