UNIVERSITY OF CALIFORNIA, SAN DIEGO UCSD

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UC SAN DIEGO DIVISION OF EXTENDED STUDIES
STUDENT SERVICES
TEL: (858) 822-1366 FAX: (858) 246-1031

9500 GILMAN DRIVE DEPT 0176H
LA JOLLA, CALIFORNIA
92093-0176
extendedstudies.ucsd.edu

Documentation Form for ADD/ADHD

The student listed below has requested academic accommodations from Student Services at UC San Diego Division of Extended Studies.

In order for Student Services to determine eligibility and arrange for appropriate accommodations, your diagnosis and assessment of this student is required. Please complete this form in its entirety and return it to Student Services at UC San Diego Division of Extended Studies as quickly as possible. The Disability Coordinator will be unable to arrange appropriate accommodations for the student until completed documentation is received. All information will be kept confidential.

Attached is the "University of California Practices for the Documentation and Accommodation of Students with Attention-Deficit/Hyperactivity Disorder" to assist you in completing this form thoroughly and completely.

Student Name _____ DOB _____

Student ID Number _____

Name/Title of Certifying Professional (Please print) _____

License # _____ State _____

Address _____

Telephone Number _____ Fax Number _____

Signature _____ Date _____

TO BE COMPLETED BY STUDENT

Student Authorization:

I, _____, am requesting academic support services through UC San Diego Division of Extended Studies Student Services. They require current and comprehensive documentation of my disability/medical condition prior to receiving services through UC San Diego Division of Extended Studies. I acknowledge that by requesting academic accommodations, I am authorizing the UC San Diego Division of Extended Studies Student Services Disability Coordinator to discuss information relevant to my disability with my medical provider. I understand UC San Diego Division of Extended Studies will keep my information confidential as per UC Policy and Procedures Manual Section 160-2.

Student Signature: _____ **Date:** _____

TO BE COMPLETED BY CERTIFYING PROFESSIONAL

1. What is the DSM diagnosis for this student? Please complete ALL axes and indicate any co-occurring diagnoses. If there are multiple diagnoses on Axis I, list in order of severity with the most severe listed first.

   Axis I _____
   Axis II _____
   Axis III _____
   Axis IV _____
   Axis V (GAF score) _____

2. What is the initial date of the diagnosis? _____

3. Is the student currently under your care? YES NO

4. When did you first see/treat the student for this diagnosis? _____

5. When was your most recent appointment with the student? _____

6. Level of Severity without Treatment (Please Circle): 1 2 3 4 5 6 7 8 9 10
   Mild Moderate Severe

   Level of Severity with Treatment (Please Circle): 1 2 3 4 5 6 7 8 9 10
   Mild Moderate Severe

7. Please indicate which of the following assessments or evaluation procedures were used to arrive at the diagnosis. Include copies of any educational/medical history and/or any neuropsychological or psycho-educational testing.

[ ] Structured/Unstructured Interviews with the Student
[ ] Interviews with Others
[ ] Behavioral Observations
[ ] Developmental History
[ ] Educational History
[ ] Medical History
[ ] Neuropsychological Testing (dates) _____
[ ] Psycho-educational Testing (dates) _____
[ ] Standardized or Non-Standardized Ratings Scales
[ ] Other (specify) _____

8. Describe the student's **current and specific functional limitations** imposed by the disability:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

9. Activities Assessment: Please check which of the activities are affected because of the diagnosis / impairment and indicate the level of limitation for each. For each activity, indicate if you observed it and/or if it was self-reported by the student. If not applicable, please check the box marked "N/A."

Activity	Level of Limitation				Observation		N/A
	Negligible	Mild	Moderate	Severe	Self-Reported	Medical Professional	
Organization							
Concentration							
Memory							
Time Management							
Stress Management							
Sleeping							
Social Interactions							
Attendance							
Managing Distractions							

10. Describe any medications and/or treatments currently being used by the student including type, dosage, effectiveness, and side effects. How frequently has medication/treatment been changed?

_____
_____
_____
_____
_____

11. Explain how medication modifies the impact that the disability has on the student's condition.

_____
_____
_____
_____
_____

12. Is the student compliant with his/her treatment plan? YES NO

13. Is the student compliant with medication/therapeutic protocols? YES NO

14. Is the student compliant with recommended referrals? YES NO

15. What is the student's prognosis?

_____
_____
_____
_____
_____

16. Please attach any other supporting documentation including psycho-educational assessments or neurological evaluations.