UCIrvine | Disability Services Center
Student Affairs

100 Disability Services, Irvine, CA, 92697-5250
949.824.7494 949.824.3083 *fax*

Verification of Attention Deficit/Hyperactivity Disorder Evaluation

Student Name (Please PRINT clearly) ______________________________ Birthdate ______________

I am requesting academic support services through the Disability Services Center at UCI. In order to determine eligibility for services, DSC requires documentation of the student's Attention Deficit/Hyperactivity Disorder (ADHD). In addition to the requested information, please attach all supportive information, reports and test results relevant to the documented diagnosis and limitations. Please respond to the following questions as soon as possible and return to me or send by mail or fax. I authorize the Disability Services Center at UCI to contact you if clarification is needed.

Student Signature ______________________ Date __________ UCI ID # ______________

Physician/Provider Name (print)**:** ______________________________ **Title:** ______________

Phone: ______________________________ **Fax:** ______________________________

Organization & Address: ____

1. **The Health Care Professional listed above must complete this form in its entirety.**
2. **Please describe the resulting limitations, symptoms, and/or side effects of medications experienced by the student in the educational environment.**

DSM/ICS Code	Disorder or Condition	Limitations/Symptoms/Side Effects
V Code/Z Code	**Psychosocial /Environmental**	**Limitations/Symptoms/Side Effects**

WHODAS (Disability) Score __________ (0-100)

Additional Questions

______________ Date of Diagnosis | ______________ Date of Initial Meeting | ______________ Date of Last Professional Contact | ______________ Frequency of Visits (i.e. weekly, monthly, etc.)

1. Is the individual currently in treatment with you? (Please circle one) Yes No

2. In addition to the DSM criteria, how did you arrive at your diagnosis?

- ☐ **Structured/unstructured interviews with the student**
- ☐ **Interviews with other persons**
- ☐ **Behavioral observations**
- ☐ **Developmental History**
- ☐ **Educational History**
- ☐ **Medical History**
- ☐ **Neuro-psychological/Psycho-educational testing**
  Date(s) of Testing: ______________________
- ☐ **Standardized or non-standardized rating scales**
- ☐ **Other:** ______________________

3. Is there anything else you would like us to know about the student? *(Optional)*

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Prognosis: ______________________________ **Expected Duration:** ______________________

This information is correct and accurate to the best of my knowledge on my recent evaluation of this patient and/or my review of records.

Physician Signature: ______________________________ **License #:** __________ **Date:** __________

All information on this form will remain confidential.