TEXAS A&M INTERNATIONAL UNIVERSITY

Autism Spectrum Disorders Packet

Disability Services for Students

This information submitted to Disability Resources should reflect the most currently available information. **This Autism Spectrum Disorders Packet should:**

a) **Be completed by a qualified professional.**

b) **Be completed as clearly and thoroughly as possible.** Incomplete responses and illegible handwriting will require additional follow up.

c) **Be supplemented with reports or additional testing, if appropriate.** Please do not provide case notes or rating scales without a narrative that explains the results.

COVID-19 Update: While the university is minimizing in-person interactions and activities, Disability Resources is recommending that documentation and request forms NOT be sent by mail or fax since staff access to these communication mediums may be limited.

For any questions, contact our office at (956) 326-3086. Fax (956) 326-2231

Submit Information Electronically to:
disabilityservices@tamiu.edu

TEXAS A&M INTERNATIONAL UNIVERSITY

The information below is to be completed and signed by the Provider.

Date: _____ Student ID: _____

Student Name: _____ DOB: _____
Last First M.I.

1. Please list all DSM-5or ICD Diagnoses (<u>name and at least one code</u>):

Diagnoses:

1. _____ _____ _____
2. _____ _____ _____
3. _____ _____ _____
4. _____ _____ _____
5. _____ _____ _____

DSM-5 diagnosis name(s) DSM-5 code(s) ICD-10 code(s)

a. Date diagnosed: _____ /_____/_____
b. Date of your last clinical contact with student: _____ /_____/_____

2. Evaluation

a. How did you arrive at this diagnosis? Please check all relevant items below, adding brief notes that you think might be helpful to us as we determine eligibility for accommodations.

- ❖ Structured or unstructured interviews with student.
- ❖ Interviews with other persons (i.e. parent, teacher, therapist).
- ❖ Behavioral observations.
- ❖ Neuropsychological testing. Attach documentation.
- ❖ Psychoeducational testing. Attach documentation.
- ❖ Other (Please specify)

_____

b. Current treatment being received by student:

- ❖ Medication management:

Current medications: _____

- ❖ Outpatient therapy:

  Frequency: _____

- ❖ Group therapy:

  Frequency: _____

- ❖ Other (please describe):

  _____

c. Approximate onset of diagnosis:

- ❖ Child-approximate age: _____
- ❖ Adolescent-approximate age: _____
- ❖ Adult-approximate age: _____
- ❖ Unknown: _____

Severity of symptoms

- ❖ Mild
- ❖ Moderate
- ❖ Severe

Prognosis of disorder:

- ❖ Good
- ❖ Fair
- ❖ Poor

Please explain: _____

_____

3. Functional Limitations: Should be determined WITHOUT consideration of mitigating measures (i.e. medication, etc.). If condition is episodic in nature, level of functioning should be assessed based on active phase of symptoms.

a. Does this condition **significantly limit one or more of the following major life activities**?

	No Impact	Moderate Impact	Substantial Impact	Don't Know
Communicating				
Concentrating				
Hearing				
Learning				
Manual Tasks				
Reading				
Seeing				
Thinking				
Walking				
Working				
Other				

b. Please check the **functional limitations or behavioral manifestations** for this student:

	Not an Issue	Moderate Issue	Substantial Issue	Don't Know
Understanding Nonverbal Behaviors				
Peer Relationships / Emotional Expression				
Cognitive Processing				
Memory				
Processing Speed				
Meeting Deadlines				
Attending Class				
Organization				
Reasoning				
Stress				
Appetite				
Other				

c. Please describe in detail any functional limitations that fall into the substantial range.

_____

_____

d. Special considerations, e.g. medication side effects: _____

_____

_____

e. ***COURSE LOAD REDUCTION***: Is the student's condition such that it may require them to drop a course and/or take fewer than what is considered a full-time course load?

- ❖ Yes ___
- ❖ No ___
- ❖ I don't know ___

If YES please explain: _____

_____

4. Accommodations

a. Please mark whether student has utilized accommodations in the past.

- ❖ Yes-Please describe:

  _____

- ❖ No _____
- ❖ Don't Know _____

b. (Optional) Recommended educational accommodations:

_____

_____

c. (Optional) Please provide any additional information you feel will be useful in determining the nature and severity of the student's disability, and any additional recommendations that may assist in determining appropriate accommodations and interventions:

_____

_____

Thank you for your help in providing this information so that we may begin services as soon as possible. Please complete the provider information below. This form should be signed and returned electronically via email or by fax to the DSS office shown at the bottom of this document. ***All documentation submitted to the DSS office is considered confidential.***

Provider Information

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

Provider Name (Print) and Title: _____

Provider Signature: _____

License or Certification #: _____ State License: _____

Address: _____

Phone: _____ FAX: _____

Submit information electronically to:

disabilityservices@tamiu.edu