ADHD: Accommodation Support Form

NOTE: Please type or print your answers on this form.

Student Information

Student Name:				
Student ID Number:				
Campus Address:				
Local Phone Number:				
Date of Birth:				
Date of Evaluation:				
Student's Presenting Concerns				
Please check all that apply. Difficulty sustaining attention Issues with time management Difficulty finishing exams in the time allowed	 □ Difficulty finishing tasks/projects □ Lack of organizational skills □ Problems taking lecture notes □ Social difficulties □ Other 			
Diagnosis				
Please check all that apply. Student was diagnosed with AD/HD There is no childhood diagnosis, bu It is very likely that this student has a lit is unlikely that this student's difficult	t symptoms were present in childhood. AD/HD.			

Evaluation Tools

 ☐ Clinical Interview ☐ Review of academic records ☐ Information from a 3rd party ☐ Professional observation ☐ Self-report inventories. Please list. 				
Objective tests of sustained attention. Please list.				
Tests of cognitive functioning. Please list.				
Please attach test scores. Include any interpretive summary along with standard scores and percentile ranks.				
Cognitive Deficits				
This student has significant deficits in the following area(s):				
☐ Attention/Concentration☐ Long term memory☐ Executive Functioning☐ Working Memory				
Other				
Impact of Cognitive Deficits				
The cognitive deficits have the following impact on functioning in an academic setting: Please indicate to what degree this impacts the student (mild, moderate or severe). Often fails to give close attention to detail Difficulty sustaining attention Does not seem to listen when spoken to directly Difficulty in following through with tasks Disorganized and forgetful in daily activities Easily distracted by extraneous stimuli Often blurts out answers before questions have been completed, interrupts others Other				

Evidence of Impact

Please indicate in	n which setting	s the student reports of	difficulty.
Academic	□Social	☐ Occupational	☐ Other
М	easures Tak	en to Rule Out Alt	ternative Causes
What steps were	taken to rule c	out alternative causes	for this student's difficulties?
			s difficulties (i.e., additional ills/habits, etc.)?
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	Me	edication & Side E	ffects
Please list presci	ribed medicatio	ons and any reported s	side effects
-			
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Recommendations for Accommodations/Referrals

Extended time for exams (time and a half) Extended time for exams (double time) Reduced distraction environment (semi-private room) for exams Reduced distraction environment (private room) for exams Note taking assistance Referral for personal counseling Referral for time management skills training Referral for study skills training Referral for organizational skills training Referral for test taking skills training Referral for further assessment. Please indicate all that apply Alcohol and drug Depression Anxiety				
☐ OCD ☐ Other. Please list				
Evaluator Information				
Evaluator Name:				
Evaluator Title:				
Evaluator Signature:				
Address:				
Phone Number:				
Fax Number:				
Email Address:				