Autism Spectrum Disorder Certification

The student named below has applied for services from the Student Accessibility area at WCTC. In order to provide reasonable and appropriate services for students with disabilities, current and comprehensive information documenting the functional impact of the disability is required. This form is intended to assist the Student Accessibility staff in providing sufficient information so that eligibility for services can be determined. The information you provide will not become part of the student’s educational records and will be kept in the student’s confidential file. In addition to the requested information, please attach any additional information; for example, your report and any test results. Thank you for your assistance.

Student name ____________________________________________________ Date _____________________________

Date of your last contact with student ___________________________________ Student’s date of birth _______________

Documentation of Impairment

1. What is the diagnosis for this student? ________________________________________________________________
   _______________________________________________________________________________________________

2. What methods or testing instruments did you use in the current assessment? (Please attach results.)

   - Clinical interviews with the individual
   - Interviews with other individuals
   - Developmental history
   - Medical history
   - Psychological testing – date(s) of testing? ______________
   - Standardized or non-standardized rating scales
   - Other (please specify): ________________________________________________

3. Please assess degree of functional impairment due to Autism Spectrum Disorder demonstrated by your patient:

   1 = Negligible    2 = Moderate    3 = Substantial    4 = Severe    UN = Unknown

   a. Expressive communication  1  2  3  4  UN
   b. Social interaction  1  2  3  4  UN
   c. Ability to deal with change  1  2  3  4  UN
   d. Written expression  1  2  3  4  UN
   e. Attention/Concentration  1  2  3  4  UN
   f. Need for routine  1  2  3  4  UN
   g. Working with other people  1  2  3  4  UN
   h. Conceptualize skills  1  2  3  4  UN
   i. Self Esteem/Social Skills  1  2  3  4  UN
   j. Other:  1  2  3  4  UN

(continued)
4. Please expand on question 3 or describe any other functional limitations caused by this student’s impairment.

**Intervention Plan**

5. Please describe an appropriate intervention plan and indicate how the plan will be managed:

<table>
<thead>
<tr>
<th>Treatment/Intervention</th>
<th>Provide</th>
<th>Needs Referral</th>
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<tbody>
<tr>
<td>Pharmacology (name of medications)</td>
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<td>Brief Psychotherapy</td>
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<td>Long-term Psychotherapy</td>
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<td>Occupational Therapy</td>
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<td>Support/Advocacy group</td>
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<td>Compensatory Strategies (please specify)</td>
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<td>Other (please specify)</td>
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6. Please indicate which accommodations, if any, may be beneficial to this student.

- Distraction free test environment
- Extended test time
- Note taking support
- Reduced credit load
- Other __________________________________________________________________________

7. Is there anything else you would like us to know about this student?

Signature of professional __________________________________________ Date __________________________

Medical professional’s name (printed) and title __________________________________________________________

License number __________________________________________________

Address ___________________________________________________________ City __________________________

State ___________________________________________________________ Zip __________________________

Telephone number ______________________ Fax number __________________________