Autism Spectrum Disorder Certification

Student Accessibility
College Center, Room C-019
800 Main Street, Pewaukee, WI 53072
Voice/Relay: 262.691.5318 | Fax: 262.691.5089
SAO@wctc.edu

The student named below has applied for services from the Student Accessibility Office 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.

Please print legibly

1. Student's name _____ Date _____

2. Date of your last contact with student _____ Student's DOB _____

3. What is the diagnosis for this student?_____

_____

4. 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):

_____

_____

5. Please assess degree of functional limitations 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)

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Autism Spectrum Disorder Certification *(continued)*

6. Please expand on question 5 or describe any other functional limitations caused by this student's diagnosis.

Intervention Plan

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

Treatment/Intervention	*Provide*	*Needs Referral*
• Pharmacology (name of medications) _____ _____ _____	☐	☐
• Brief Psychotherapy	☐	☐
• Long-term Psychotherapy	☐	☐
• Occupational Therapy	☐	☐
• Support/Advocacy group	☐	☐
• Compensatory Strategies (please specify) _____	☐	☐
• Other (please specify) _____	☐	☐

8. Please indicate which accommodations, if any, may be beneficial to this student.

- ☐ Low distraction test environment
- ☐ Extended test time
- ☐ Note taking support
- ☐ Reduced credit load
- ☐ Other _____

9. 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 _____

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