MARQUETTE UNIVERSITY | On Your Marq

AUTISM SPECTRUM DOCUMENTATION FORM

The student named below has requested services from the "On Your Marq" autism support proram at Marquette University. In order to determine this student's eligibility for the program, we ask that you provide us current and comprehensive information attesting to the student's autism and the functional impact of ASD and co-morbid disabilities. The information you provide will be kept in the student's confidential file.

In addition to the requested information sought from this form, please attach copies of any test results or evaluations conducted as part of your diagnostic or therapeutic process.

Name of Student: _____Birth Date: _____

1. Do you see this student on a regular basis? _____ Yes_____ No
   When was your last contact with this student? _____

2. Does the student have a DSM-V diagnosis of Autism Spectrum Disorder? ___Yes ___No
   Please note any comorbid diagnoses such as ADHD, Depression, Anxiety, Bipolar, Schizophrenia, etc.:

Please note: For Questions 3-8, you may either use this form, or attach your diagnostic report.

3. Please check which of the skills listed below are substantially limited:

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* Substantially limited is defined as a "significant restriction in the condition, manner, or duration in which a major life activity is performed compared to most people."

1) Time management/Long Term planning _____
2) Organizational skills (physical and/or cognitive) _____
3) Task persistence _____
4) Memory skills _____
5) Reading (fluency, comprehension) _____
6) Quantitative skills _____
7) Written expression _____
8) Employment/work skills _____
9) Self esteem/social skills/relationships _____
10) Attention/Concentration _____
11) Language and/or communication _____
12) Daily living/self-care skills _____
13) Self-advocacy/self expresssion _____

On Your Marq Autism Support Program Marquette University P.O. Box 1881 Milwaukee, WI 53201
Phone: 414-288-0212 Fax: 414-288-5333

4. What methods or testing instruments did you use to arrive at your diagnosis?

- Structured or unstructured clinical interviews with the individual
- Interviews with other individuals
- Developmental history
- Medical history
- Neuropsychological / Psycho-educational testing
- Date(s) of testing? _____ Copy of testing results attached? ____Yes ____No
- Standardized or non-standardized rating scales
- Other (please specify)

5. What medications is this student currently taking?

1. Medication/dosage:
Purpose:
Duration taken:

2. Medication/dosage:
Purpose:
Duration taken:

3. Medication/dosage:
Purpose:
Duration taken

If the student is on medication(s), what functional limitations does the student encounter?

_____
_____
_____

6. What accommodations do you recommend for this student?

_____
_____
_____

7. Will the student require absences from class? _____ Yes _____ No _____ Unknown
If yes, please indicate the reason. *

_____ for symptoms experienced
_____ for side effects of medication or treatment
_____ for treatment of ASD or other condition

* Please note - There may be limitations on the number of absences a student is allowed based on class requirements.

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

_____
_____
_____
_____

Please sign, date and return to our office. Thank you for your assistance.

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Signature of Treating Professional

_____

Date

_____

Professional's Name (printed) and Title

_____

License Number

_____

Address

_____

Telephone Number

_____

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