

**ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD) DOCUMENTATION GUIDELINES**  
**DISABILITY PROVIDER FORM**

Your patient/client has requested accommodations through the Academic Success Office at Presbyterian College. The Academic Success Office coordinates the collection and review of documentation in conjunction with the Coordinator, Disability Support Services to provide reasonable accommodations for students with disabilities in accordance with Section 504 of the Rehabilitation Act of 1973, and with the Americans with Disabilities Act (ADA) of 1990 as amended in 2008, as well as other applicable state and federal laws.

**Student's Name** \_\_\_\_\_

**Student's Date of Birth** \_\_\_\_\_

**Date of Last Visit/Consultation** \_\_\_\_\_

Although the more generic term Attention Deficit Disorder (ADD) is often used, we will use the official nomenclature from the **Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)**, Attention Deficit Hyperactivity Disorder (ADHD).

ADHD is a neurobiological, genetic disorder, characterized by difficulty sustaining focus and attention, hyperactivity, and /or difficulty controlling behavior.

In order to be considered eligible for reasonable accommodations relating to ADHD the following documentation is required:

Current medical documentation provided by a qualified professional such as a licensed physician, psychiatrist, licensed psychologist, clinical social worker, or other mental health professional which has been provided **within three calendar years of the student's date of enrollment in Presbyterian College**. In addition, a comprehensive psychoeducational evaluation is *strongly recommended*. The medical evaluation must, at a minimum, contain the following information:

- A diagnostic statement of a specific disability including how the manifestations of which currently affect academic performance.
- Recommendations for reasonable accommodations specific to the disability and a rationale and its effect on the student's academic performance in the college setting.

**NOTE to PROVIDERS:** Please submit this completed form along with a full description of the diagnostic methodology used, including data and measurements from appropriate evaluation instruments. The results obtained should draw a direct link to the diagnosis and the functional limitations of the disability. For cognitive disorders, evaluations should use adult norms. Complete documentation is important. Inadequate information, incomplete answers and /or illegible handwriting may delay the eligibility review process for students.

1. Please cite the student's diagnosis:

**DX:** \_\_\_\_\_

Diagnostic code: \_\_\_\_\_ From:  DSM-V  IDC-10

Additional specifiers (if applicable) \_\_\_\_\_

Indicate if in:  Partial Remission  Not Applicable

Comments (if necessary): \_\_\_\_\_

2. Please indicate the level of severity for the diagnosis using the scale below:

\_\_\_\_ **Mild**- Few, if any, symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairments in social or occupational functioning.

\_\_\_\_ **Moderate**- Symptoms or functioning impairment between “mild” and “severe” are present.

\_\_\_\_ **Severe**- Many symptoms in excess of those required to make the diagnosis, or several symptoms that are particularly severe, are present, or the symptoms result in marked impairment in social or occupational functioning.

3. How does diagnosis/disability currently impact functioning, and how does it cause substantial limitation in the academic setting?

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4. Date of diagnosis: \_\_\_\_\_

5. Was the diagnosis made by you? \_\_\_\_\_ **Yes** \_\_\_\_\_ **No, DX made by:**

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6. Number of consultations with you in the past 3 years: \_\_\_\_\_

7. Date of your most recent evaluation: \_\_\_\_\_

8. Length of time under your care: \_\_\_\_\_

9. Currently under your care? \_\_\_\_\_ **Yes** \_\_\_\_\_ **No, care ended on:** \_\_\_\_\_

10. Please describe in detail the symptoms currently experienced by the student.

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11. If applicable, indicate any medications currently prescribed which may impact the student’s functioning, including any impact produced by side effects.

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12. Please indicate recommendations regarding accommodations for this student and the rationale as to why these accommodations are needed based on the student’s limitations. Clearly indicate the accommodations you are recommending.

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*I understand that the information provided will become part of the student record subject to the Federal Family Education Rights and Privacy Act of 1974 and may be released to the student on their written request.*

Provider's Signature \_\_\_\_\_ Date \_\_\_\_\_

License/Certification # \_\_\_\_\_ State \_\_\_\_\_

Name/Title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

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**DOCUMENTATION MAY BE SENT TO:**

Presbyterian College  
Academic Success Office/Accommodations  
503 S. Broad Street  
Clinton, SC 29325  
Email: [accommodations@presby.edu](mailto:accommodations@presby.edu)