Northwestern | QATAR

Office of Academic Advising and Student Success

AD/HD Verification Form

NOTE: This form is to be filled out, in its entirety, by the professional who is treating the student. This professional must be unrelated to the student, and any information provided by a family member will be considered supplemental. PLEASETYPE AND SUBMIT THIS FORM ELECTRONICALLY, rather than hand-writing or printing it out.

Student Information

Student Name *

First

Last

Certified Provider Information

Provider Name *

First

Last

Provider Email *

Provider Title *

License/Certification Number and Issuing State *

Provider Address *

Street Address

Address Line 2

City

Country

Phone *

-

Professional Visit Summary

Date of Initial Contact with Student *

/ /

MM DD YYYY

Date of Most Recent Formal Contact/Appointment with Student *

/ /

MM DD YYYY

Approximate Frequency of Contact with Student since Initial Contact *

Date of Completion of Form *

/ /

MM DD YYYY

Diagnostic Information

Date of Diagnosis *

/ /

MM DD YYYY

List the diagnostic procedures, assessments, and scales used to make the diagnosis. (A complete psychoeducational or neuropsychological evaluation is preferred in lieu of completing this form.) *

Age at onset of symptoms: *

Describe the settings in which these symptoms have been most evident. *

Differential diagnosis: Explain how other psychiatric or medical disorders that may cause problems with inattention and/or hyperactivity-impulsivity were considered, evaluated, and documented or ruled out. Please also discuss any alternative or coexisting conditions. *

Treatment Information

Medications

Current medication(s) including dosage, effectiveness, and side effects: *

Date of most recent medication change and compliance with medication plan: *

Educational and Behavioral Interventions

What academic interventions, coaching support, or other behavioral programs have been made available, and what was their level of effectiveness? *

Impact of Condition on Educational Success

Identify the specific academic abilities or functions that are compromised by the disorder, and indicate severity of these limitations: *

Suggested Accommodations

NOTE: Final determination of appropriate accommodations will be determined by AccessibleNU in accordance with the mandates of the Rehabilitation Act of 1973 and the Americans with Disabilities Act as well as court rulings and Department of Education Office of Civil Rights rulings related to these two laws. Each recommended accommodation must be accompanied by an explanation of its relevance to the diagnosed disability.

Extended time for exams? *

- [ ] Yes
- [ ] No

Explanation of relevance/justification:

Quiet room in which to take exams? *

- [ ] Yes
- [ ] No

Explanation of relevance/justification:

Other recommended accommodations (please specify in the field below): *

- [ ] Yes
- [ ] No

Certifying Authority

Add your signature in the box below. *

I understand this is a legal representation of my signature.

Date

MM / DD / YYYY