ADHD DOCUMENTATION FORM

STUDENT INFORMATION

Name (Last, First, Middle): ________________________________________________________________

Date of Birth: ___________________ Institution: ____________________________________________

Status (check one): ___ Current Student ___ Transfer Student ___ Prospective Student

Phone: ___________________________ Email Address: _______________________________________

Mailing Address: ________________________________________________________________

__________________________________________________________

DIAGNOSTIC INFORMATION

(To be completed by Qualified Healthcare Provider. Please print legibly or type.)

*Illegible and/or Incomplete forms will delay the documentation review process for the student.

Please provide responses to the following items.

1. DSM-V Diagnosis: 314.00 ADHD

   ___ 314.01 (F90.2) Combined presentation: If both criteria for Inattention and
   Hyperactivity/Impulsivity are met for the past 6 months.

   ___ 314.00 (F90.0) Predominantly Inattentive presentation: If criteria for Inattention is met
   but criteria for Hyperactivity/Impulsivity is not met for the past 6 months.

   ___ 314.01 (F90.1) Predominantly Hyperactivity/Impulsivity presentation: If criteria for
   Hyperactivity/Impulsivity is met but criteria for Inattention is not met for the past 6 months.

   ___ 314.01 (F90.8) Other Specified ADHD: Symptoms characteristic of ADHD cause significant
   impairment in social, occupational, or other areas of functioning are present but do not meet
   the full criteria for ADHD or any other neurodevelopmental disorders, and the clinician chooses
   to communicate the specific reason why the full criteria of ADHD is not met.

   ___ 314.01 (F90.9) Unspecified ADHD: Symptoms characteristic of ADHD cause significant
   impairment in social, occupational, or other areas of functioning are present but do not meet
   the full criteria for ADHD or any other neurodevelopmental disorders, and the clinician chooses
   not to communicate the specific reason why the full criteria of ADHD is not met.
2. **State the following:**
   a. Date of diagnosis:  
   c. Date of last contact with the student:  
   b. Date of first contact with the student:  
   d. Comorbid conditions:

3. **Student’s History**
   a. ADHD History (inattention and/or hyperactivity during childhood):  
      Document symptoms that were present during early school years. Provide information supporting the diagnosis based on independent sources (e.g., past evaluations, school records, teacher report). Please attach copies of previous psychological evaluations.  
   b. Medical History:  
      Provide relevant medical history. Is the student currently taking medication for ADHD? Are they experiencing any side effects with this medication?
4. **Student’s Current Specific Symptoms:**
   Please report ADHD symptoms listed in the DSM-V that the student currently exhibits that interfere with social, academic, and occupational functioning **during the past 6 months**. Please attach copies of psychological evaluation and/or standardized rating scales used to determine diagnosis completed by independent observers in at least two settings (not including patient and clinician). **Examples of suggested assessment measures include:**
   - continuous performance tests (VIGIL, TOVA, Conners, IVA) and Barkley Adult ADHD Rating Scale – IV (BAARS-IV).
   - Additional information on suggested assessment measures are found at: [rcld.gsu.edu/evaluators](http://rcld.gsu.edu/evaluators)

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**HEALTHCARE PROVIDER INFORMATION**

(Please sign & date below and fill in all other fields completely. Please print legibly or type.)

Provider Signature: ________________________________ Date: __________________

Provider Name (Print): __________________________________________________________

Title: _______________________________________________________________________

License or Certification #: ______________________________________________________

Address: _____________________________________________________________________

Phone Number: ______________________ Fax Number: __________________________
FUNCTIONAL IMPAIRMENT

(To be completed by Qualified Healthcare Provider or Disability Service Provider. Please print legibly or type.)

Please state the student’s functional impairments in an academic environment (classroom setting) based on the student’s specific ADHD symptoms. Functional impairment must directly link the symptom to the impact the student experiences in the academic environment. (What academic tasks are adversely impacted due to ADHD symptoms and how?)

Completed By:

Name (Print): __________________________________________________________

Title: __________________________________________________________________

Signature: ____________________________ Date: ____________________________