Lake Michigan College Student Outreach and Support Services
Serving Benton Harbor, South Haven, and Niles Campuses
2755 E. Napier Ave Benton Harbor, MI 49022
Phone: (269) 927-8866 Fax: (269) 927-6536

DISABILITY DOCUMENTATION FORM:
AUTISM SPECTRUM DISORDERS

PLEASE REVIEW CAREFULLY

The individual named below has applied for services from the Student Outreach and Support Services (SOSS) at Lake Michigan College. Lake Michigan College provides academic accommodations to individuals with disabilities. Individuals seeking services must provide appropriate medical documentation of their condition so that the SOSS can: a) determine eligibility for accommodations, and b) if eligible, determine appropriate accommodations.

The Americans with Disabilities Act (ADA) defines disability as "a physical or mental impairment that substantially limits one or more major life activities, a record of such impairment, or being regarded as having such an impairment." Disabilities involve substantial limitations and are distinct from common conditions not substantially limiting major life activities.

Documentation required to verify the condition, severity, and functional limitations includes completion of this form or provision of equivalent information to the SOSS by a licensed mental health professional. Depending on the condition, the appropriate professional should be a licensed psychiatrist, psychologist, neurophysiologist, or other qualified and licensed medical or diagnostic professional. Professionals completing this form must have first-hand knowledge of the condition, experience in working with students with autism spectrum disorders and ideally a familiarity with the physical, emotional and cognitive demands experienced by students in an academic setting. Diagnoses of disabilities documented by family members are unacceptable.

Client Information

____
Client name: Last First Middle Initial

Date of Birth: ________ Client's LMC Student ID (eight digits): ________________________

Certifying Professional

Certifying Professional's Printed Name: _________________________________

Credentials/Specialization: ____

License Type: ____

License #:___________________ State: ______Exp. Date: ______

Mailing Address: ____

City/State/Zip:____

Phone: (_____)_______________ Fax: (_____)_______________

Email: _____________________________

Office web address: ____

Attach Business Card Here
or

Denote your Office Web Address

Diagnosis/Diagnoses: Please include DSM Codes and name of condition(s)

Date of onset: Date of diagnosis:

Diagnostic Tools: How did you arrive at your diagnosis/diagnoses? Please check any relevant items below:

- ☐ Interviews with the client
- ☐ Interviews with other persons
- ☐ Behavioral observations
- ☐ Developmental history
- ☐ Medical history
- ☐ Neuro-psychological testing
- ☐ Psycho-educational testing
- ☐ Self-rated or interviewer rated scales
- ☐ Other

Prognosis

Expected Duration of Primary Condition: (Check One)

☐Permanent ☐Temporary

Characteristics of Limiting Condition(s): (Check All That Apply)

☐Stable ☐Episodic ☐Slow Progression ☐Rapid Progression ☐Improving

Additional comments/information

Medication, Treatment, and Prescribed Aids

What medication(s) are currently being used to address the diagnosis/diagnoses above? Fully describe impact of medication side-effects that may adversely affect the client's academic or workplace performance.

What treatment and prescribed aids (i.e. counseling, therapy, support groups) are currently being used to address the diagnosis/diagnoses above?

Is the client compliant with medication and prescribed aids as part of the treatment plan? If no, please explain:

Date of last appointment:

How often does your client receive treatment?

☐Weekly ☐Monthly ☐Annually ☐As needed

Implications for Academic/Student Life

Major Life Activity	**Impacts** Please check the severity of impacts	**Recommendations for Accommodations and Services** Please provide specific recommendations to address impacted major life activities
Concentration	☐None ☐Moderate ☐Substantial ☐Unsure	
Long Term Memory	☐None ☐Moderate ☐Substantial ☐Unsure	
Short Term Memory	☐None ☐Moderate ☐Substantial ☐Unsure	
Sleeping	☐None ☐Moderate ☐Substantial ☐Unsure	
Eating	☐None ☐Moderate ☐Substantial ☐Unsure	

Major Life Activity	**Please check the severity of impacts**	**Recommendations for Accommodations and Services** Please provide specific recommendations to address impacted major life activities
Social Interactions	☐None ☐Moderate ☐Substantial ☐Unsure	
Self-Care	☐None ☐Moderate ☐Substantial ☐Unsure	
Managing Internal Distractions	☐None ☐Moderate ☐Substantial ☐Unsure	
Managing External Distractions	☐None ☐Moderate ☐Substantial ☐Unsure	
Time Management	☐None ☐Moderate ☐Substantial ☐Unsure	
Motivation	☐None ☐Moderate ☐Substantial ☐Unsure	
Stress Management	☐None ☐Moderate ☐Substantial ☐Unsure	
Organization	☐None ☐Moderate ☐Substantial ☐Unsure	

Major Life Activity	**Please check the severity of impacts**	**Recommendations for Accommodations and Services** Please provide specific recommendations to address impacted major life activities
Other (Explain): _____________	☐None ☐Moderate ☐Substantial ☐Unsure	
Other (Explain): ______________	☐None ☐Moderate ☐Substantial ☐Unsure	

Please print this documentation, sign and date below. Send or fax directly to SOSS using the contact information on page one.

Date:

Certifying Professional's Signature:

____

Signature denotes: content accuracy, adherence to professional standards and guidelines on page 1 of this document.