



Please submit this completed verification form to:

College Assistance Program, Iona College

715 North Avenue, New Rochelle, NY

10801

Attention Deficit/Hyperactivity Disorder Verification Form

The College Assistance Program (CAP) at Iona College requires verification of AD/HD. This verification must be completed by a **credentialed professional**. Once this verification is received, CAP can determine applicant eligibility for our LD Program. NOTE: This information is not part of the applicant's educational record, and will be kept confidentially in the student's non-academic file.

1. Student/Applicants Name _____
2. Today's Date _____ Date of Diagnosis _____
3. Applicant is seen: on a regular basis occasionally as needed seen only for this evaluation
4. Is the student/applicant taking medication(s) for ADD/ADHD yes no
5. If yes, please list medications: _____

6. Dates prescribed _____
7. Effectiveness _____
8. Side effects _____
9. Please share any other information that you feel is important for us to know about this applicant
10. Please fill out the next section in compliance with the format of the DSM-IV-TR (Diagnoses and Axes information)

Axis I (Clinical Disorders)	
Axis II (Personality Disorders and Mental Retardation)	
Axis III (General Medical Conditions)	
Axis IV (Psychological and Environmental Problems)	
Axis V (Global Assessment Function Rating)	

In addition to the DSM-IV-TR criteria, please indicate how you arrived at your diagnosis. Check ALL that apply:

- Medical History
 Educational History
 Developmental History
 Behavioral Observations
 Interviews with the parent
 Interviews with the client (structured/unstructured)
 Psycho-educational testing that you performed
 Psycho-educational testing that you reviewed
 Neuro-educational testing that you performed
 Neuro-educational testing that you reviewed
 Standardized or un-standardized assessments (Please specify) _____
 Other (please specify) _____

Please indicate the level of functioning/level of limitation in regards to life activities

Life Activity	No Impact	Mild Impact	Moderate Impact	Severe Impact	Don't Know
Sleeping					
Memory					
Concentration					
Stress					
Time management					
Keeping appointments					
School Attendance					
Organization					
Handing in school work on time					
Handling Internal Distractions					
Handling External Distractions					

Certifying Professional

Name (please print) _____ Signature _____

License # _____

Phone Number(_____) _____ Email _____@ _____

Expertise:
 Neurologist
 Psychiatrist
 School Psychologist
 Other _____