Attention Deficit/Hyperactivity Disorder (AD/HD)

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 along with all necessary application materials, CAP can determine if an applicant is eligible for our LD program. **NOTE:** This information is not part of the applicant’s educational record, and will be kept confidential in the student’s non-academic file.

1. Student/Applicant 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 this 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-5 or ICD-10:
Attention-Deficit/Hyperactivity Disorder

☐ 314.01 (F90.2) Combined Presentation (inattention & hyperactivity-impulsivity)

☐ 314.00 (F90.0) Predominantly inattentive presentation

☐ 314.01 (F90.1) Predominantly hyperactive/impulsive presentation

☐ 314.01 (F90.8) Other specified Attention-Deficit/Hyperactivity Disorder

Specify current severity: □ Mild □ Moderate □ Severe
**In addition to the DSM-5 or ICD-10 criteria, please indicate how you arrived at your diagnosis. Check ALL that apply:**

- [ ] Medical History
- [ ] Educational History
- [ ] Developmental History
- [ ] Behavioral Observation
- [ ] Interviews w/parent
- [ ] Interview w/client (structured/unstructured)

Testing:
- [ ] Psycho/Neuro-Educational Performed
- [ ] Psycho/Neuro-Educational Reviewed
- [ ] Standardized or un-standardized assessments:

  ________________________________________________

- [ ] Other (please specify):

  ________________________________________________

**Please indicate the level of functioning/level of limitation in regard to the following:**

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<th>No Impact</th>
<th>Mild Impact</th>
<th>Moderate Impact</th>
<th>Severe Impact</th>
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**Certifying Professional**

Name (please print):_____________________________________________________
Signature:_____________________________________________________________
License Number:_________________________________________________________
Phone Number:___________________________________________________________
E-Mail:______________________________________________________________

  Qualification:  
  - [ ] Clinical Psychologist
  - [ ] Neuropsychologist
  - [ ] Psychiatrist
  - [ ] Physician (MD)

Date:_______________________________________________________________

RETURN TO:  **College Assistance Program**
Iona College
715 North Avenue
New Rochelle, NY 10801

  **Tel:** 914-633-2159  
  **Fax:** 914-633-2011