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:

	No Impact	**Mild Impact**	**Moderate Impact**	**Severe Impact**	**N/A**
Sleep					
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 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