



Baton Rouge Community College
Counseling & Accessibility Services

ATTENTION DEFICIT/HYPERACTIVITY DISORDER (AD/HD) DOCUMENTATION REQUEST FORM

****This form must contain ALL of the REQUESTED INFORMATION and be TYPED or PRINTED in order to apply for accommodations through the Office of Counseling & Accessibility Services.****

Student's Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Student Campus ID # _____

This student is requesting an auxiliary aid or service, academic adjustment, and/or other accommodations from the Office of Counseling & Accessibility Services due to AD/HD. In order to consider this request, as well as to ensure the provision of reasonable and appropriate auxiliary aids and services, college policy requires that a **Qualified Professional** provide current and comprehensive documentation of AD/HD. A qualified professional includes a licensed psychiatrist, psychologist, medical doctor, or other qualified mental health professional **who is not a family member of the student. IN ORDER TO BE CONSIDERED CURRENT, THE QUALIFIED PROFESSIONAL'S STATEMENT MUST BE WITHIN 3 YEARS PRIOR TO THE DATE OF THE MOST RECENT REQUEST FROM DISABILITY SERVICES.**

The documentation provided must include information that diagnoses the AD/HD, describes the functional limitations in an educational setting, and indicates the severity and longevity of the AD/HD for the purpose of determining academic adjustment(s) or other accommodation(s).

To facilitate the gathering of such critical information, please respond to the following and return to BRCC Office of Counseling & Accessibility Services.

1. Diagnosis (as diagnosed by the DSM-V): _____

2. If you have a formal evaluation, please attach it.

3. Date of Diagnosis: _____ Date of Last Contact with Student: _____

4. Provide a **summary** of the student's educational, medical, and family history that may relate to AD/HD (must demonstrate that difficulties are not the result of sensory impairment, serious emotional disturbance, cultural differences, or insufficient instruction): _____

5. What **current medication(s)** have been prescribed? _____

6. Describe the student's **functional limitations** in an educational setting: _____

7. Please indicate the **RECOMMENDATIONS** you have regarding necessary and appropriate auxiliary aids or services, academic adjustments or other accommodations to equalize the student's educational opportunities at BRCC.

Please check all that apply: extended time (1.5x) distraction-reduced environment
 volunteer note taker

Please note: If any other accommodations are being requested, additional documentation WILL BE REQUIRED.

Qualified Professional's Signature: _____

Printed Name & Title: _____

Daytime Telephone Number: _____

Address: _____

Date: _____

NOTE: Our policy regarding documentation prohibits the dissemination of documentation to you or anyone requesting it once it is received. Therefore, once this form is submitted, we will be unable to disseminate copies to anyone.

Counseling & Accessibility Services
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