DOCUMENTATION VERIFICATION
FOR
ATTENTION DEFICIT HYPERACTIVTY DISORDER (ADHD)

Name: _____ DOB: _____

Social Security Number: _____

1. DSM IV Diagnosis:
   _____

   Date of Diagnosis: _____ Last Contact with this person: _____

2. What instruments and procedures were used to diagnose the ADHD? Please check all relevant items.

   _____ Clinical Interview
   _____ Developmental History
   _____ Medical history
   _____ DSM-IV diagnosis
   _____ Neuro-psychological testing: date(s) of testing _____
   _____ Psycho-educational testing: date(s) of testing _____
   _____ Other (please specify)

   _____ Interview with other persons
   _____ Educational history
   _____ Behavioral rating scale

3. Describe symptoms that meet the criteria for this diagnosis and report all test results. Attach an interpretive diagnostic report. Include severity of impairment, duration and expected long-term impact.

4. Describe how this disorder exhibits itself as a history of impairment in multiple domains. Include areas such as impairment in work, education, social/peers, home life, and/or family relationships.

5. List any co-morbid diagnoses. Do these conditions contribute to the person's impairment?

6. List current prescribed medication(s), dosage, frequency and possible adverse side effects

7. List any recommendations you have for support this person needs due to ADHD

8. Describe any other relevant information you may have that has not been addressed.

Please note: This office will not accept disability-related documentation from treatment professionals who are related, in any way, to the person requesting services.

Signature:_____ Date: _____

Print name and title:_____

Address: _____ Phone: _____

_____

_____

Please return this form to:

THIS DOCUMENT IS AVAILABLE IN ALTERNATIVE FORMAT UPON REQUEST.