

**DOCUMENTATION VERIFICATION
FOR
ATTENTION DEFICIT HYPERACTIVITY 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	_____ Interview with other persons
_____ Developmental History	_____ Educational history
_____ Medical history	_____ Behavioral rating scale
_____ DSM-IV diagnosis	
_____ Neuro-psychological testing: date(s) of testing	_____
_____ Psycho-educational testing: date(s) of testing	_____
_____ Other (please specify)	

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: