

Disability Resources Office

# Documentation for ADD/ADHD

**Please have your provider complete this form and send to:**

**Sue Sprague, Director; Disability Resources Office; SUNY Cortland; PO Box 2000; Cortland, NY 13045**

**Office: (607) 753-2967; Fax: (607) 753-5495; E-Mail:** [**disability.resources@cortland.edu**](mailto:disability.resources@cortland.edu)

|  |  |  |  |
| --- | --- | --- | --- |
| Health professional’s name: |  |  | ***Stamp or Sign Here*** |
| (please print) |  |  |  |
| Date: |  |  |  |
| Clinic name and address: |  |  |  |
|  |  |  |  |
| Clinic Phone: |  |  |  |
| Student Name: |  |  |  |
|  |  |  |  |

1. What is the diagnosis?
2. Date diagnosis was made?
3. Is the patient/student currently under your care?
   * Yes
   * No
4. What date did you last see the patient/student?
5. Please check all major life activities listed below that are affected as a result of the diagnosis.

|  |  |  |  |
| --- | --- | --- | --- |
| **Level of Limitation** | Negligible | Moderate | Substantial |
| **Writing** |  |  |  |
| **Performing manual tasks** |  |  |  |
| **Sleeping** |  |  |  |
| **Learning** |  |  |  |
| **Reading** |  |  |  |
| **Thinking** |  |  |  |
| **Concentrating** |  |  |  |
| **Memorizing** |  |  |  |
| **Taking exams** |  |  |  |
| **Interacting with others** |  |  |  |
| **Other:** |  |  |  |

1. What are the Functional Limitations resulting from the diagnosis that impact on major life activities identified in #5?
2. Based upon the major life activities affected by the diagnosis, are there any accommodations within the context of college that you can recommend?
3. Medications
4. Medication side-effects