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Services for Students with Disabilities

Documentation of Asperger’s Syndrome
Confidential

TO BE COMPLETED BY STUDENT:

I hereby authorize _____ to

Release to and discuss with the Rider Services for Students with Disabilities

Office the information specified below.

Signature: _____ Date: _____

To ensure the provision of reasonable and appropriate accommodations for students with *Asperger’s Syndrome* at Rider University, **this form must be completed by an appropriate professional (e.g. psychiatrist, neurologist, psychologist, neuropsychologist).**

TO BE COMPLETED BY PROFESSIONAL:

Name of Student: _____ Date of Birth: _____

DSM IV diagnosis: _____ DSM IV
code: _____

Date of Original Diagnosis: _____ Date student was last seen: _____

1) Please provide the following:

Date of most current evaluation: _____

Diagnostic criteria/assessment tools used: _____

2) Psychological History- Please provide pertinent psychological history (include any psychological reports or tests, if applicable).

3) Pharmacological History – Please provide pertinent pharmacological history, including an explanation of the extent to which the medication has mitigated the symptoms of the disorder in the past.

4) Psychosocial History- Provide pertinent information obtained from the student/parent(s)/guardian(s) regarding the student’s psychosocial history (e.g. history of not sustaining relationships, history of employment difficulties, history of educational difficulties, social inappropriateness, history of risk taking or dangerous activities, etc.).

b) How does the prescribed medication attenuate the negative impact of the student's disability?

8) What other information do you consider relevant to this student's ability to succeed in a college setting?

9) **Please attach all relevant assessment data (including clinical interview, results of psychological / psychiatric evaluation, and standardized test scores).**

Signature: _____

Print Name and Title: _____

License # _____

Address: Agency Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Return this form to: Services for Students with Disabilities
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