Disability Support Services

Current Status Report of Autism Spectrum Disorder
To Be Completed By Psychiatrist/Psychologist/Clinician
Please TYPE or PRINT

Patients Name:

1) Diagnosis of condition (include: DSM-5 code, date of onset and last date patient seen)

2) Describe the symptoms, severity, and longevity of the condition.

3) Describe functional limitations in an educational setting.

4) Describe Current Status.

5) Offer recommendations for accommodations.

Signature: ___________________________ Date: ___________________________
Print Name and Title: ___________________________
Agency or Organization: ___________________________
Address: ___________________________ Phone: ___________________________

Return by fax with Voluntary Statement to:
Attn: Disability Support 781-275-7126 or email at disabilityservices@middlesex.mass.edu