middlesex community college

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