

U OF T ACCESSIBILITY SERVICES STUDENT DOCUMENTATION FORM

Dear Student,

This form is designed to provide Accessibility Services with confirmation that you have a disability and with information on how your disability will impact your studies at university. Click here for more information on documentation for a learning disability.

The mandate of Accessibility Services is to provide reasonable and appropriate academic accommodations while maintaining academic integrity of the degree, using OHRC guidelines. Accessibility Services will use the information provided by your health care provider to work with you to determine what accommodations you will need while you are studying. Please bring this form to a health care professional who knows you well.

Disclosing a mental health diagnosis is a choice and is **not** required to receive accommodations. Please indicate below if you give consent for your regulated health care provider to disclose your diagnosis. Any information provided on this form will be used in accordance with the guidelines outlined in Section 39(2) of the Freedom of Information and Protection of Privacy Act, 1990 (FIPPA).

ATTENTION STUDENT: This document, once completed by your Health Practitioner, should be uploaded when you complete the online Student Intake Form. If you are unable to upload your document, you can return it to Accessibility Services in person (455 Spadina Avenue, 4th floor, Suite 400, Toronto ON M5S 2G8), or you can fax a copy to 416-978-5729, or you can email an electronic copy to accessibility.intakes@utoronto.ca Remember, before we can proceed with the Intake process, you must also have submitted the online Student Intake Form.

ATTENTION HEALTH PRACTITIONER: If you are preparing this form for a student registering with Accessibility Services, the student has a separate questionnaire that they must complete and submit to the Accessibility Services office. If you will be submitting this form directly to our office on behalf of the student, please fax to: 416-978-5729, or email a copy to: accessibility.intakes@utoronto.ca

STUDENT INFORMATION

Student Name: _____ Student Number _____

U of T Email: _____ Preferred Phone Number: _____

Date of Birth: _____ / _____ / _____ (yyyy/mm/dd)

I will / will not be required to complete lab/fieldwork/practicum/placement) as part of my program.

Type of fieldwork/practicum/placement: _____

RELEASE OF INFORMATION

TO BE COMPLETED BY THE STUDENT (prior to asking a Health Care Professional to complete Certificate of Disability)

I hereby authorize my Health Care Professional named here: _____ to share information concerning the functional impact(s) of my disability(ies) with Accessibility Services at University of Toronto.

Student's Signature: _____ Date _____

CONSENT TO DISCLOSURE OF MENTAL HEALTH DIAGNOSIS TO ACCESSIBILITY SERVICES

- I consent to my mental health diagnosis being identified on this form and provided to Accessibility Services, University of Toronto.
- I do not consent to my mental health diagnosis being identified on this form

HEALTH PROFESSIONAL WITH AUTHORITY TO MAKE A RELEVANT DIAGNOSIS

You have been asked by a student who wishes to register with Accessibility Services at the University of Toronto (St. George Campus) to complete the enclosed documentation. Accessibility Services supports students who **require academic accommodation for a permanent or temporary disability** using the OHRC to guide decision making. Interim accommodations may be provided for students being assessed for mental health disabilities in keeping with OHRC guidelines.

The purpose of the documentation is to enable Accessibility Advisors to recommend reasonable and appropriate academic accommodations for students with disabilities who experience functional restrictions and limitations affecting their performance in academic classroom/lab/practicum/placement/field work settings. The post-secondary environment involves taking examinations, doing research, completing assignments, working in practicum and professional placement settings and generally assuming personal responsibility for one’s higher education pursuits

We rely on your detailed knowledge of this student’s disability, including a list of the functional limitations and restrictions that may impact on their learning and demonstrating their knowledge and skills.

Please note that any information provided on this form will be used in accordance with the guidelines outlined in Section 39(2) of the Freedom of Information and Protection of Privacy Act, 1990 (FIPPA).

Documentation must be provided by a regulated health practitioner licensed to diagnose.

HEALTH CARE PRACTITIONER INFORMATION

Name of Health Practitioner <i>(please PRINT):</i>					
Facility Name and address - <u>Please use official stamp</u> Note: If you do not have an office stamp please sign and attach your letterhead. Signatures on prescription pads will NOT be accepted.		Specialty:			
		<input type="checkbox"/> Audiologist <input type="checkbox"/> Family Medicine <input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Neurologist <input type="checkbox"/> Neuropsychologist <input type="checkbox"/> Neurosurgeon <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Ophthalmologist		<input type="checkbox"/> Optometrist <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Psychologist <input type="checkbox"/> Rheumatologist <input type="checkbox"/> Speech Language Pathologist <input type="checkbox"/> Other regulated health practitioner: <hr/>	
Health Practitioner Signature:				Registration/ License No.	
Date		Telephone Number		Fax Number	

STATEMENT OF DISABILITY

The provision of a diagnosis in the documentation is voluntary however, disability documentation must still confirm the student’s type of disability and the functional limitations. If the student consents, please provide a clear diagnostic statement; avoiding such terms as “suggests” or “is indicative of”. If the diagnostic criteria are not present, this must be stated in the report.

If the student does not permit the disclosure of the diagnosis, please verify that a disability is present. There will be some instances where a diagnosis is required to establish eligibility for specific support (e.g., funding).

Please note any multiple diagnoses or concurrent conditions.

Nature of Disability	Primary Disability	Date of Diagnosis	Reviewed other Documentation	Other Disability(ies)	Date of Diagnosis	Reviewed other Documentation
	<i>Indicate ONE only</i>	Diagnosed by you <input type="checkbox"/> Yes / <input type="checkbox"/> No		<i>Indicate ALL that apply</i>	Diagnosed by you <input type="checkbox"/> Yes / <input type="checkbox"/> No	
Acquired Brain Injury	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No
Attention Deficit (Hyperactivity) Disorder	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No
Autism Spectrum Disorder	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No
Chronic Physical Illness	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No
Deaf, Deafened, Hard of Hearing	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No
Low Vision, Blind	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No
Mental Health	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No
Physical Mobility	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No
Other*	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No	<input type="radio"/>		<input type="radio"/> Yes/ <input type="radio"/> No

*Reminder: For LD and ADHD see LD documentation guidelines [Check Here](#). A regulated health practitioner may make an ADHD diagnosis.

Nature of the Disability: Please provide a specific diagnosis below.

Student consent specifically for the disclosure of a mental health diagnosis is required (see page 1 consent)

DURATION:

- Permanent disability** with on-going (chronic or episodic) symptoms (that will impact the student over the course of his/her academic career and is expected to remain for his/her natural life).
- Temporary** with anticipated duration from: ____/____/____ to ____/____/____ (Year, Month, Day).
If duration is unknown, please indicate reasonable duration for which the student should be accommodated/supported (please specify): _____ (number of weeks, months) **OR Term ending:** May 1 June 15 Aug 30 Dec 31.
- Must be reassessed every _____ due to the changing nature of the illness or requires follow up for monitoring.
- I am in the process of monitoring and assessing** the student’s health condition to determine a diagnosis and this assessment is likely to be completed by _____ (Please Note: Updated documentation will be required to continue to provide academic accommodations).
- Date of Next Clinical Assessment** ____/____/____ (Year, Month, Day) Interim accommodations may be provided during the assessment period. Updated documentation will be required to provide continued accommodation.

CLINICAL METHODS TO DIAGNOSE DISABILITY AND IDENTIFY FUNCTIONAL LIMITATIONS

Select all that apply:

- Clinical Assessment.** Dates: _____
- Diagnostic Imaging/ Tests.** Please indicate all that apply: MRI CT EEG X-Ray
- Neuropsychological Assessment** (please provide a copy of the report which includes the list of tests completed and the scores)
- Psychiatric Evaluation.** Dates: _____
- Psycho-Educational Assessment** (please provide a copy of the evaluation)
 - If ADHD, indicate assessment tools utilized for diagnosis:
 - Check list administered Report Cards Interview
- Writing Aids Assessment** (please provide a copy of the Occupational Therapy report)
- Behavioural Observations**
- Other:** _____

ACQUIRED BRAIN INJURY/CONCUSSION

Date of Acquired Brain Injury/Concussion: _____

Is there a prior history of Acquired Brain Injury/Concussion? Yes No Unknown

Description of the current injury and its impact on functioning i.e., the ability to meet academic/placement and other related student obligations:

- HEARING** Please attach a copy of the most recent audiogram. Symptoms are: Stable Progressive

	Left Ear	Right Ear
Hearing loss (specify type and severity)		
Tinnitus (please check)		
Other (please specify):		
Does the student's hearing fluctuate? Is so, please describe:		

- VISION** Symptoms are: Stable Progressive
Dx: _____

	Visual Acuity	Visual Acuity – Best Corrected	Visual Field	Visual Field – Best Corrected
OD				
OS				
OU				
Other comments on diagnosis (e.g., night vision, depth perception, ocular mobility/balance, colour perception, constriction, etc.):				

CURRENT TREATMENT (OPTIONAL, PLEASE CHECK ALL THAT APPLY)

Treatment	Start Date	Anticipated End Date	Frequency
Chiropractic Therapy			
Massage Therapy			
Neuropsychological Assessment/Counselling			
Occupational Therapy			
Outpatient ABI Treatment Program			
Physiotherapy			
Psychotherapy			
Speech Language Therapy			
Other			

Further Description of Treatment Modalities

How long have you been treating the student? _____ First visit: _____ Last visit: _____

Do you monitor and or treat the student on a regular basis? Yes No

MEDICATION TREATMENT

Medication Side Effects: When are adverse or side-effects of any prescribed medication likely to negatively affect the student's academic functioning (check all that apply):

- Morning Afternoon Evening N/A

Level of Impact (by medication) on Academic Functioning:

- Mild Moderate Severe N/A

Please list side effects of medication(s) which may impact academic functioning:

HEADACHES/MIGRAINES

<input type="checkbox"/> Headaches	Triggers:
	Impact:
<input type="checkbox"/> Migraines	Triggers:
	Impact:

SEIZURES

Type of Seizure	Management <i>(e.g., rarely occurs; well controlled with medication; needs rest or break; always call 911)</i>
<input type="checkbox"/> Focal (partial seizures), with retained awareness	
<input type="checkbox"/> Focal (partial seizures) with loss of awareness	
<input type="checkbox"/> Absence seizures (petit mal)	
<input type="checkbox"/> Tonic-Clonic/convulsive seizures (grand mal)	
<input type="checkbox"/> Atonic seizures (drop attacks)	
<input type="checkbox"/> Clonic seizures	
<input type="checkbox"/> Tonic seizures	
<input type="checkbox"/> Myoclonic seizures	
<input type="checkbox"/> Psychogenic non-Epileptic seizures	

RESTRICTIONS AND LIMITATIONS

IMPORTANT NOTICE: As this certificate covers the impact of all types of disabilities, there are questions that may not be relevant to the student. Check **only** the areas that apply.

- Where noted, please indicate the restriction and impacts/functional limitations on the student’s daily living, academic functioning and participation in practicum/clinical settings.
- Indicate the severity of disability based on number of symptoms, severity of symptoms and functional impact in an academic environment.

Mild: The student should be able to cope with minimal support. Functional limitation evident in this area.

Moderate: The student requires some degree of academic accommodations, as symptoms are more prominent.

Serious: The student has a high degree of impairment. Significant academic accommodations may be required as symptoms and impact interferes with academic functioning.

Severe: Completely unable to function at any academic level or meet academic obligations even with accommodations.

VISION	Mild	Moderate	Serious	Mild to Serious	Severe	Recommendations to manage impact/What alleviates Symptoms?
Eye fatigue/strain after _____ minutes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Restricted ability to view screen and read academic material	<input type="checkbox"/> >1hr	<input type="checkbox"/> 30-60 mins.	<input type="checkbox"/> <15 mins.	<input type="checkbox"/>	<input type="checkbox"/>	
Other (specify): _____ _____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PHYSICAL	Mild	Moderate	Serious	Mild to Serious	Severe	Recommendations to manage impact/What alleviates Symptoms?
Ambulation <input type="checkbox"/> Short Distance <input type="checkbox"/> Other (e.g. uneven ground)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Standing (e.g. sustained standing in laboratory) <input type="checkbox"/> No prolonged standing, specify mins. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sitting for sustained period of time (e.g. in lecture /exam) <input type="checkbox"/> No prolonged sitting, specify mins _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

This section to be completed by Regulated Health Care Practitioner

PHYSICAL (Continued)	Mild	Moderate	Serious	Mild to Serious	Severe	Recommendations to manage impact/What alleviates Symptoms?
Stair Climbing <input type="checkbox"/> None <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lifting/Carrying/Reaching <input type="checkbox"/> No lifting/carrying more than _____ lbs. <input type="checkbox"/> Limited reaching/pushing/pulling <input type="checkbox"/> Limited ROM (specify) <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Grasping/Gripping Dominance: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Minimize repetitive use <input type="checkbox"/> Limited dexterity (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neck <input type="checkbox"/> No prolonged neck flexion <input type="checkbox"/> Reduced ROM <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pain <input type="checkbox"/> Chronic <input type="checkbox"/> Episodic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Skin <input type="checkbox"/> Avoid contact with _____ _____ <input type="checkbox"/> Other: _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bowel and Urinary <input type="checkbox"/> Frequent (which may impact academic activities such as writing an exam) <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stamina <input type="checkbox"/> Reduced stamina <input type="checkbox"/> Frequency of rest breaks (e.g. minutes per hour) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SLEEP CYCLES & ENERGY	Mild	Moderate	Serious	Mild to Serious	Severe	Recommendations to manage impact/What alleviates Symptoms?
Fatigue <input type="checkbox"/> Temporary due to medication side effects. Expected duration: _____ <input type="checkbox"/> Fluctuating energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sleep Disorder or difficulties _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Note: Students are encouraged to create healthy sleep habits and to discuss this with their health-care practitioner so as to minimize the impact at school.

This section to be completed by Regulated Health Care Practitioner

COGNITIVE	Mild	Moderate	Serious	Mild to Serious	Severe	Recommendations to manage impact/What alleviates Symptoms?
Concentration difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty with organization/time management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Low motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Executive functioning (ability to multi-task, prioritize, organize and manage time)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty staying on and completing tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Judgement and insight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty with managing workload	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Becomes overwhelmed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Need to ask for additional clarification and feedback on performance in lab/clinical/placements/practicum/ related learning,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other impacts and restrictions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PARTICIPATION/SOCIAL INTERACTION	Mild	Moderate	Serious	Mild to Serious	Severe	Recommendations to manage impact/What alleviates Symptoms?
Significant difficulty in social participation <i>(This may cause difficulties with participating in class and group settings)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Significant difficulty related to speaking in public or presentations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty understanding common social cues <i>(e.g., do not pick up on metaphors, humour, facial expressions)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other impact and restrictions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

HEALTH & SAFETY	Comments
Difficulty operating machinery <i>(e.g. scientific or lab equipment, engineering machinery)</i>	<input type="checkbox"/> MILD: Should only operate with minimal supervision <input type="checkbox"/> MODERATE: Should only operate with constant supervision <input type="checkbox"/> SEVERE: Should never operate, with or without supervision
Difficulty handling dangerous or hazardous substances/chemicals	<input type="checkbox"/> MILD: Should only handle with minimal supervision <input type="checkbox"/> MODERATE: Should only handle with constant supervision <input type="checkbox"/> SEVERE: Should never handle, with or without supervision
Student has a physical health condition such that the university may need to respond in an emergency situation if symptoms of the condition appear while the student is on campus or during fieldwork. <i>(e.g. seizure disorder, severe allergic reaction)</i>	If "Yes": please describe condition(s) and recommended response. Comments:
Other: (please specify)	

SUPPORTS RECOMMENDED BY THE HEALTH CARE PROVIDER FOR UNIVERSITY LEARNING

The Accessibility Advisor will discuss these recommendations with the student to determine an appropriate accommodation plan. Please specify.

- The student has been advised to reduce his/her course or program load.
- Service Animal (e.g., autism support, guide dog, seeing eye dog, psychiatric service dog, mobility support animal, seizure alert animal) Type of animal: _____
- Peer Notetaking
- Extensions for written work
- Recommendations for thesis completion; comprehensive exams; oral defense
- Recommendations for practicums; placements or lab work
- Other: _____