Lakehead UNIVERSITY | Student Accessibility Services

MEDICAL DOCUMENTATION FORM

This form is to be completed and signed by the student PRIOR TO asking a health care professional to complete the Medical Documentation Form

The form below is to be submitted by students seeking disability related accommodations to a licensed health care professional in order to register with Lakehead University's Student Accessibility Services (SAS).

Students are not required to disclose their specific disability diagnosis in order to register with Student Accessibility Services(SAS) to receive academic accommodation. The Ontario Human Rights Commission recognizes that Disability Services Offices have expertise in dealing with accommodation issues in the academic environment, and as such, play a vital role in assisting with the accommodation process. If students wish to, they may voluntarily disclose their diagnosis to SAS.

Providing diagnoses may be required to establish eligibility for certain federally or provincially funded bursaries and grants and privately funded external scholarships and financial awards. This Form can therefore also be used to establish eligibility for such financial assistance, provided the student has consented to the disclosure of their disability diagnosis.

This form and its articulated purpose is consistent with the Ontario Human Rights Commission's Policy on preventing discrimination based on disabilities and the Lakehead University Documentation Guidelines for Students with Disabilities/Medical Conditions.

If you choose to consent to the disclosure of your disability diagnosis, you must check the box below. Your consent will allow your Health Care Practitioner to complete the additional section of the Form.

☐ I consent to disclose the diagnosis of my specific disability

☐ I do not consent to disclose the diagnosis of my specific disability

Student Signature

Student Name(Please print):

Date of Birth(mm/dd/yyyy):

Student Number:

Phone :

Lakehead Email Address:

Campus:

Dear Health Care Practitioner,

You have been asked by a student who wishes to register with Student Accessibility Services (SAS) at Lakehead University to complete the enclosed documentation. SAS is a Disability Service Office for students who **require academic accommodation for a permanent or temporary disability.** Interim accommodations can be provided for students who are in the process of being assessed for a mental health disability.

As you know, the post-secondary environment involves taking examinations, doing research, completing assignments, and assuming responsibility for one's higher education pursuits. The purpose of the SAS medical/psychological documentation is to enable Disability Advisors to recommend appropriate academic accommodations for students with disabilities who experience functional restrictions and limitations which affect their academic participation and performance.

We are accountable under the Ontario Human Rights Code and the Lakehead University Senate Policy on Accommodations for Students with Disabilities. These guidelines help us provide equitable academic accommodations that level the playing field for students with disabilities without creating an unfair advantage or undermining academic integrity. **We rely on your detailed knowledge of this student's disability to complete the following form which includes providing a list of the functional limitations and restrictions that may impact their education together with any other relevant information. Please note that unless the student's signed consent is attached, we do not require the student's diagnosis.**

Thank you for helping to reduce barriers for students with disabilities while upholding the academic standards of the university.

This form must be completed by a licensed medical practitioner or registered psychologist

If you have any questions or concerns, please contact our office:

Thunder Bay Campus
Phone: (807) 343-8047
Fax: (807) 346-7733
E-mail: sas@lakeheadu.ca
955 Oliver Road
Thunder Bay ON P7B 5E1

Orillia Campus
Phone: (705) 330-4010 Ext. 2103
Fax: (705) 329-4035
E-mail: oraccess@lakeheadu.ca
500 University Avenue
Orillia ON L3V 0B9

To be completed by Health-Care Practitioner

PATIENT INFORMATION (Please Print)

First name: _____ Last name:_____

Date of Birth: Day: _____ Month: _____ Year: _____

As this certificate covers the impact of all types of disabilities there are questions that may not be relevant to your patient. Check only the areas that apply.

CONFIRMATION OF DISABILITY

Identify the broad area of the disability, and only provide a specific diagnosis (*Dx) if the student has agreed to do so on page 1.

☐ **Acquired Brain Injury**
*Dx:_____

☐ **Attention Deficit Hyperactivity Disorder** *Dx:_____
Was a Psychological Assessment completed? _____ If yes, please attach

☐ **Hearing**: please attach a copy of the most recent audiogram

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

☐ **Learning Disability** *Dx:_____Attach Psychological Assessment

☐ **Medical** *Dx:_____

☐ **Mental Health Disability/ Psychiatric**

* Dx (DSM V) (**Major Depressive, Bi-Polar, Generalized Anxiety, Panic Disorder, ASD, etc.)**

_____

How long have the symptoms presented (in months or years)? _____

☐ **Mobility/Physical**

*Dx: _____

☐ **Vision** *Dx: _____

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

☐ **Other** *Dx:_____

To be completed by Health-Care Practitioner

STATEMENT OF DISABILITY

The following criteria must be met when determining a disability. Refer to page two for further information.

1. The student experiences functional limitation(s)
2. The functional limitation(s) impairs the student's academic functioning at the post-secondary level

Select the appropriate option:

☐1. This student has a **permanent** disability with symptoms that are ☐ continuous OR ☐ episodic

☐2. This student has a **temporary** disability with symptoms that are ☐ continuous OR ☐ episodic

Interim academic accommodations to be provided until (date)*: _____

☐3. This student is being **monitored** to determine a diagnosis

Interim academic accommodations to be provided until (date)*: _____

* Updated documentation required after this date

Medication

If this student has been prescribed medication for this condition, when is the medication likely to have a negative effect on their academic functioning? (Check all that apply)

☐ Morning ☐ Afternoon ☐ Evening ☐ N/A

List the functional limitations (adverse effects) which may impact academic performance;

_____

_____

_____

RESTRICTIONS AND FUNCTIONAL LIMITATIONS

What are the impacts/ functional consequences and restrictions/ limitations on the patient's daily living and academic functioning?

Where noted, please 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 as minimal symptoms present and will have slight impact on functioning

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

Severe: The student has a high degree of impairment with significant academic accommodations required as symptoms and impact markedly interfere with academic functioning

To be completed by Health-Care Practitioner

COGNITIVE	Comments…
☐ Cognitive fatigue requiring rest due to acquired brain injury (including concussion) ☐ Student advised to withdraw from school activities until effects of injury subside ☐ Date to return to studies:	
☐ Distractibility	☐ Mild ☐ Moderate ☐ Severe
☐ Diminished ability to think or concentrate	☐ Mild ☐ Moderate ☐ Severe
☐ Memory deficit (e.g., head injury, learning disability) ☐ Concentration impacts memory	☐ Mild ☐ Moderate ☐ Severe
☐ Information processing (written and verbal) impaired	☐ Mild ☐ Moderate ☐ Severe
☐ Difficulty with organization and time	
☐ Low motivation	
☐ Difficulty staying on, and completing, tasks	
☐ Other impact and restrictions:	
Communication and Social	**Comments/ If applicable, recommendations to manage impact/ What Alleviates Symptoms**
☐ Deficits in oral communication for social purposes (e.g., saying hello)	
☐ Significant difficulty in social participation (This may cause difficulties with participating in class and group settings)	
☐ Significant difficulty related to speaking in public or presentations	
☐ Difficulty understanding what is not explicitly stated (e.g., do not pick up on metaphors, humour, etc.)	
☐ Other impact and restrictions:	
HEADACHES/MIGRAINES	**Comments…**
☐ Headaches ☐ Migraines Triggers and impact of headache/migraine: Frequency of headache/migraine:	☐ Mild ☐ Moderate ☐ Severe ☐ Can range mild-severe

To be completed by Health-Care Practitioner

PHYSICAL	Comments…
Ambulation ☐ Activity as tolerated ☐ Restrictions: ☐ Short distance only ☐ Other- (uneven ground)	
Standing ☐ Activity as tolerated ☐ Restrictions ☐ No prolonged standing specify number of mins. ☐ Loss of Balance ☐ Other:	
Sitting ☐ Activity as tolerated ☐ Restrictions ☐ No prolonged sitting specify number of mins. ☐ Other:	
Stair climbing ☐ None ☐ Activity as tolerated ☐ Other:	
Lifting/Carrying/Reaching ☐ Advised not to carry/lift more than: ☐ Limited reaching, pushing pulling ☐ Limited range of motion)please specify): ☐ Other:	
Grasping/gripping ☐ Dominant hand please circle: Left Right ☐ Minimize repetitive use ☐ Limited dexterity (please specify)	
Neck ☐ No prolonged neck flexion ☐ Reduced range of motion ☐ Other	
Pain ☐ Chronic ☐ Episodic	☐ Mild ☐ Moderate ☐ Severe ☐ Can range mild-severe ☐ Impact on academic functioning:
Skin ☐ Avoid contact with: ☐ Must wear personal protective equipment or devices in handling chemicals and animals (e.g., non-latex gloves)	
Bowel and Urinary ☐ Frequent (which may impact academic activities such as writing an exam) ☐ Other:	☐ Mild ☐ Moderate ☐ Severe ☐ Can range mild-severe

To be completed by Health-Care Practitioner

STRESS MANAGEMENT	**COMMENTS…**
☐ Difficulty with high pressure situations (e.g., managing multiple deadlines, multiple exams heavy workload)	☐ Mild ☐ Moderate ☐ Severe
☐ Easily overwhelmed and response to stress is out of proportion to situation	☐ Mild ☐ Moderate ☐ Severe
☐ Other impact and restrictions:	
☐ Sleep disorder:_____ 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.	☐ Mild ☐ Moderate ☐ Severe ☐ Impact on academic functioning:
SEIZURE DISORDER	**Comments**…
☐ Type(s):_____	
☐ Restrictions:_____	☐ Frequency:_____ ☐ Triggers:_____ Recommended response in the event a seizure occurs at school: _____
HEALTH AND SAFETY	**Comments…**
☐ Must not operate machinery	
☐ Must not handle dangerous chemicals	
☐ Other (please specify):	

Do you consider the student capable of:
Sustaining normal academic activity in their program of choice? ☐Yes ☐No If no, please comment:

Participating in a work/field placement? ☐Yes ☐No If no, please comment:

CURRENT TREATMENT PLANS AND GOALS

☐ Physiotherapy:

☐ Counselling:

☐ Referred to specialist- type of specialist:

CLINICAL METHODS TO DIAGNOSE DISABILITY

- ☐ Diagnostic Imaging/Test (please circle): **MRI CT EEG X-Ray**
- ☐ Neuropsychological Assessment (please provide a copy of the report)
- ☐ Psychiatric Evaluation Dates:
- ☐ Psycho-educational Assessment (please provide a copy of the assessment)

To be completed by Health-Care Practitioner

BACKGROUND AND FOLLOW UP

If Motor Vehicle Accident: Date of Accident(YYYY/M/D):

How long have you been treating this patient?

Last date of Clinical Assessment:

Next appointment:

RECOMMENDED SUPPORTS AT UNIVERSITY

☐ The patient has been advised to reduce his/her course load _____

☐ Academic Accommodations may need to be considered as the patient was unable to attend school from _____ until_____.

☐ Service animal (Please attach SAS Service Animals on Campus Documentation Form.)

☐ Accessible parking space

☐ Other: _____

HEALTH CARE PRACTITIONER INFORMATION	
Name of Health Practitioner (please PRINT):	
Facility Name and address - <u>Please use office 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:** ☐ **Audiologist** ☐ **Chiropractor** ☐ **Family Medicine** ☐ **Gastroenterologist** ☐ **Neurologist** ☐ **Neurosurgery** ☐ **Optometrist** ☐ **Ophthalmologist** ☐ **Psychiatrist** ☐ **Physiotherapist** ☐ **Psychologist** ☐ **Rheumatologist** ☐ **Other:** _____
Health Practitioner Signature:	**Registration No.**
Date	**Telephone No.** **Fax No.**

Student Consent

Completion of this section is voluntary; however, if you elect not to provide your consent at this time and in the event that further information is required there may be delays in the provision of your accommodation.

I give consent for SAS to contact my medical practitioner or registered psychologist to discuss the information provided in this document if necessary to clarify the information provided regarding functional restrictions and limitations or if there are questions about complex academic accommodation.

Student's Signature: _____

Date: (mm/dd/yyyy): _____

Witness's Signature: _____

Date: (mm/dd/yyyy): _____

****Note to student:** Please note - additional documentation may be requested

Personal information on this form is collected under the authority of the Act Respecting Lakehead University and the Ontario Human Rights Code and will be used in support of the provision and tracking of learning accommodations. Any questions on this collection should be directed to: Manager, Student Accessibility Services, SC0003D, Lakehead University, 955 Oliver Road, Thunder Bay, Ontario P7B 5E1; telephone: (807) 343-8086.