Student Accessibility Services
Medical Information Request Form

IMPORTANT NOTE REGARDING THIS FORM
This form is not meant for you if your accommodation needs: • Are the result of a non disability-related extenuating circumstance –

PART A: TO BE COMPLETED BY THE STUDENT

Dear Student,

This form is designed to provide **Student Accessibility Services at Confederation College** with confirmation that you have a disability and with information on how your disability will impact you while studying at Confederation College.

The mandate of Student Accessibility Services (SAS), informed by the Ontario Human Rights Code, is to provide individualized academic accommodations to equalize learning opportunities. SAS 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 at Confederation College. The regulated health care professional who completes this form will be asked to use their assessment and detailed knowledge of you to describe the functional impact of your disability. Please bring this form to a health care professional who knows you well.

Disclosing a diagnosis is a choice and is not required to receive accommodations from SAS. Please indicate below if you give consent for your regulated health care provider to disclose your diagnosis.

Any information provided on this form is kept strictly confidential and will not be shared with anyone outside of Student Accessibility Services - Confederation College without your explicit written consent.

STUDENT INFORMATION

Name: _____ Date of Birth (D/M/Y): _____
Student Number: _____ Email: _____
Preferred Phone Number: _____
Will you be required to complete fieldwork/placements? ◯ Yes ◯ No
Type of fieldwork: _____
Date fieldwork begins (D/M/Y): _____

CONSENT TO RELEASE INFORMATION

I _____(your name) authorize my health care professional to provide information outlined in this form to Student Accessibility Services at Confederation College.

CONSENT TO DISCLOSURE OF DIAGNOSIS

◯ I consent to my diagnosis being identified on this form and provided to Student Accessibility Services at Confederation College.
◯ I do not consent to my diagnosis being identified on this form

Student Signature: _____ Date (D/M/Y):_____

PART B: TO BE COMPLETED BY THE HEALTH CARE PROFESSIONAL

Dear Health Care Professional,

You are being asked to complete the following Documentation Form by a student who wishes to register with **Student Accessibility Services (SAS) at Confederation College**. We seek the following information:

1. Confirmation that the student has a disability
2. Confirmation of functional limitations the student experiences directly related to their disability or health condition

We rely on your assessment and detailed knowledge of this student and their disability to provide us with a description of the current functional limitations that impact the student in the academic context. Please use the form that follows to identify the functional limitations that impact the student in the academic context. In some cases, students will complete the functional limitations section themselves. If this is the case, we ask that you initial each functional limitation indicated by the student with which you agree.

By initialing in agreement, you are indicating that you have assessed this functional limitation and are in agreement that the limitation is present OR based on your knowledge of the student's condition, this limitation is related to the student's diagnosed disability(ies).

The information you provide, along with the information provided by the student, will be used by SAS to design an individualized accommodation plan. This plan helps to ensure the student has an equitable opportunity to fulfill the essential academic requirements and standards at Confederation College.

Disclosing a diagnosis is not required to access accommodations from SAS. You are asked to only provide a diagnosis with the student's consent on the CONFIRMATION OF DISABLITY page of this form. Any information provided on this form will be kept strictly confidential and will not be shared with anyone outside of Student Accessibility Services- Confederation College without the student's written consent.

CERTIFICATION OF REGULATED HEALTH CARE PROFESSIONAL

Practitioners Name (print): _____

Phone: _____ Fax: _____

License/Registration Number: _____

Regulated Health Care Professional:
- ◯ Physician – Family
- ◯ Physician – Speciality
- ◯ Psychologist/Psychological Associate
- ◯ Other Regulated Health Care Professional

Practice Stamp*

Stamp

Practitioner's Signature: _____ Date (D/M/Y): _____

***Note**: if you do not have an official stamp, please sign, date, and attach a sheet of your Office Letterhead

CONFIRMATION OF DISABILITY
(To be completed by the Health Care Professional)

Please Note: If this student's functional limitations are a result of **a non-disability related extenuating circumstance**, please have the student consult with their respective postsecondary accessibility office rather than completing this form.

The following criterion MUST BE MET for the determination of a disability: The student experiences functional impairments due to a disability or diagnosed health condition that impacts the student's academic functioning while pursuing postsecondary studies

DURATION OF DISABILITY

The designation of permanent disability has legal implications and is used in determining a student's eligibility for government programs.

Disability Duration:

- ◯ Permanent disability – ongoing, will impact the student over the course of their academic career, and is expected to remain for the person's lifetime
- ◯ Ongoing disability – unknown duration
- ◯ Temporary disability
  - Anticipated duration: _____(M/Y) to _____(M/Y)
- ◯ Diagnosis unconfirmed (Note: interim accommodations offered under these circumstances may require periodic documentation from professionals)
  - Assessment likely to be completed by: _____(M/Y)
  - Next clinical assessment appointment: _____(M/Y)

Notes/Comments:_____
_____
_____

Has the student consented to providing their diagnosis(es) in Part A? ◯ Yes ◯ No

If Yes, please provide the diagnostic statement(s): _____
_____

EXPECTED CHANGES IN LEVEL OF FUNCTIONING

◯ Condition is expected to remain stable	◯ Condition is expected to fluctuate significantly
◯ Condition is expected to decline	◯ Changes in level of functioning are difficult to predict

Does this student have a disability that is episodic in nature (i.e., periods of good health interrupted by periods of illness or disability)? ◯ Yes ◯ No

If the student's functioning is restricted at certain times of the day, please specify when:

◯ Morning ◯ Afternoon ◯ Evening ◯ Not applicable

FUNCTIONAL LIMITATIONS
(To be completed by the Health Care Professional)

Please check all functional limitations the student experiences specifically due to their disability

Note: *If the student completes this section of the form, we ask health care providers (HCP) to initial those functional limitations with which they agree, based on their clinical assessment and judgement.*

COMMUNICATION ◯ Not Applicable

Condition significantly restricts ability to:	Yes	HCP Initial
Organize and communicate ideas in written form	◯	
Organize and communicate ideas verbally	◯	
Present orally to a group or class	◯	
Participate in large class	◯	
Participate in online discussions	◯	
Participate in small group or lab activities	◯	

COGNITIVE ◯ Not Applicable

Condition significantly restricts ability to:	Yes	HCP Initial
Recall information after a delay – long term memory (e.g., recalling information during an exam)	◯	
Recall information that is stored for a short period of time – short term memory (e.g., recalling what was read or following a conversation)	◯	
Hold and manipulate information – working memory (e.g., listening to lecture and summarizing in note form)	◯	
Complete a series of academic tasks scheduled in close sequence (e.g., several assignments/tasks in same week, multiple exams in one day)	◯	
Complete a timed academic task (e.g., timed exam)	◯	
Complete scheduled academic tasks on time when given advance notice (e.g., class assignments/projects)	◯	
Process written or verbal information	◯	

COGNITIVE (CONTINUED)

Condition significantly restricts ability to:	Yes	HCP Initial
Interpret and follow instructions	◯	
Maintain focus on academic tasks in a setting with visual distractions (e.g., other students writing exams in neighbouring desks)	◯	
Maintain focus on academic tasks in a setting with auditory distractions (e.g., other students writing or turning pages during an exam)	◯	
Organize, sequence, and prioritize academic tasks	◯	
Plan and set goals to meet deadlines	◯	
Read for up to 3 hours	◯	
Complete cognitively straining tasks for up to 3 hours	◯	
Pay attention (e.g., lectures or exams) for up to 3 hours	◯	

SOCIAL/EMOTIONAL ◯ Not Applicable

Condition significantly restricts ability to:	Yes	HCP Initial
Effectively read social cues (e.g., following classroom protocols)	◯	
Regulate emotions (e.g., while interacting with others in the class as well as the professor, accepting constructive feedback)	◯	
Complete academic tasks while being evaluated (e.g., exams, placement, oral presentation)	◯	
Respond to changes in classrooms, assignment deadlines, class schedules	◯	
Participate in group or lab activities with assigned or chosen peers (i.e., work with a group or partner to achieve a goal)	◯	
Maintain personal hygiene (e.g., body odour)	◯	

SOCIAL/EMOTIONAL (CONTINUED)

Condition significantly restricts ability to:	Yes	HCP Initial
Restrict ability to follow group learning etiquette (e.g., not interrupting lectures, participating in small group discussions)	◯	

SENSORY ◯ Not Applicable

Condition significantly restricts ability to:	Yes	HCP Initial
Use of a computer for academic purposes	◯	
See the whiteboard/projector in a lecture hall	◯	
See regular print (e.g., 12 pt. font) on a computer screen or on paper	◯	
Hear the professor in a large lecture hall (with a microphone in use)	◯	
Hear other individuals in a small classroom setting	◯	
Hear conversations in a setting with background noise	◯	
Hear dialogue in videos, process live dialogue during online class discussions		
Process visual stimuli (i.e., sensitivity to light, certain colours)	◯	
Process auditory stimuli (i.e., sound sensitivities)	◯	
Process tactile or olfactory stimuli (i.e., touch/texture and smell sensitivities)	◯	

PHYSICAL ◯ Not Applicable

Condition significantly restricts ability to:	Yes	HCP Initial
Lift, carry, reach overhead, twist, bend, kneel (i.e., gross motor movements)	◯	
Walk to, from, and between classes with backpack and books/computer	◯	
Handle and manipulate small objects - fine motor movement (e.g., work with test tubes or beakers in a lab setting)	◯	
Handwrite for up to 3 hours	◯	
Sit for up to 3 hours (e.g., in class, lab, exams)	◯	
Stand for up to 3 hours (e.g., labs, placements)	◯	
Regulate motoric activity (e.g., fidgeting in class, labs)	◯	

OTHER FUNCTIONAL LIMITATIONS NOT LISTED*****:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

* If student self-reported functional limitations, **health care professional agrees that limitations are directly related to the student's disability/disabilities**:
HCP's initials: _____

TREATMENT PLAN
(To be completed by the Health Care Professional)

How long have you been treating the student? _____

Date of determination of disability (D/M/Y): _____

The confirmation of disability is based on (**CHOOSE A or B**):

◯ **A**. I have recently assessed this student and I am knowledgeable about their disability and related functional impairments.
◯ **B**. I have expertise in this area of disability and have reviewed current documentation provided by this student that gives a detailed assessment of their disability and related functional impairments.

Date of most recent assessment (related to this disability[ies]): _____

Will you remain involved in ongoing management and treatment of this student's disability?

◯ Yes ◯ No **If Yes,** how often? _____

If No, does this student require ongoing care? _____

Do you recommend that the student be referred for a psychoeducational assessment to determine if they have a learning disability? ◯ Yes ◯ No

Treatment Plan (e.g., recommended follow-up, referrals): _____

_____

_____

Medication Side Effects:

Is the student taking any medication which could have a negative affect on their academic functioning?
◯ Yes ◯ No

If Yes, when are the side effects of any prescribed medication likely to occur (check all that apply):
◯ Morning ◯ Afternoon ◯ Evening ◯ N/A

Medication level of impact on academic functioning:
◯ Mild ◯ Moderate ◯ Severe ◯ N/A

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

_____

_____

OTHER INFORMATION
(To be completed by Health Care Professional)

Please provide any additional information or explanation that you feel is relevant to any of the boxes checked on this form: _____

_____

_____

HEALTH CARE PROVIDERS AUTHORIZATION
(To be completed by Health Care Provider)

Health Care Provider's Signature: _____
Date: _____

Student Accessibility Services
Confederation College

Phone: (807) 475-6618
Fax: (807) 473-3744
Email: sas@confederationcollege.ca

Part A and B of this form have been adapted from Queen's University Student Accessibility Services Documentation Form (2017)