Medical, Physical, Sensory Disability Verification and Impact

Student Development Centre, Services for Students with Disabilities

Student Release of Information

I, _____, hereby authorize this health practitioner to provide the following information to Brock University, Services for Students with Disabilities (SSWD), and if required, to supply additional information about my disability, with regard to the impact and restrictions it places on my academic performance. I also authorize SSWD to consult with this medical professional to discuss recommendations and provision of accommodations.

Patient's name: _____

Patient's date of birth: _____

Patient's signature: _____

Witness signature: _____

Date: _____

Collection notice:

Brock University protects your privacy and your personal information. The personal information requested on the form is collected under the authority of The Brock University Act, 1964, and in accordance with the Freedom of Information and Protection of Privacy Act (FIPPA) for the verification and impact of the medical, physical, sensory disability form. Direct any questions about this collection to the director of the Student Development Centre at Brock University at 905-688-5550 extension 3981.

Services for Students with Disabilities Contact Information

Brock University
Student Development Centre, Services for Students with Disabilities
500 Glenridge Avenue
St. Catharines, ON L2S 3A1
Phone number: 905-688-5550 Ex. 3240 Fax number: 905-688-7260
Services for Students with Disabilities website

Information and purpose of this form

Thank you for assisting this student and the university by completing this documentation required to process a request for support services related to a medical condition.

Services for Students with Disabilities (SSWD) has the responsibility of facilitating special services and accommodations for students with disabilities. The information in this form is primarily used to support the student's request for academic accommodations. However, the information provided may also be used to assess eligibility for financial or other programs for students with disabilities while registered as a student at Brock University.

- Documentation must be provided by a licensed appropriate practitioner qualified to diagnose the condition
- Documentation must support the request for accommodations or academic adjustments and/or aids and devices and verify the functional impact of the disability on the student's academic performance

Confidentiality

Documentation provided by students is considered confidential and is treated in a way that will protect the individual's dignity. Collection, use and disclosure of this information is subject to all applicable privacy legislation.

SSWD reserves the right to contact the medical professional to clarify any information provided on this form.

To Be Completed by Health Practitioner

Statement of Disability

Careful consideration should be given to the statement below with respect to disability, severity, impact and duration. The designation of permanent disability has legal implications and is used in determining eligibility for government funding.

Permanent disability is defined as a functional limitation due to the disorder that restricts the person's ability to perform daily activities necessary to participate in post-secondary studies and is expected to remain with the person for the person's expected life.

1. In your professional opinion, does this condition meet the criteria of a permanent disability as defined above? Yes ☐ No ☐
2. Is this a permanent disability as defined above? Yes ☐ No ☐
3. If this is a temporary disability, can you anticipate the expected duration:

   FROM: _____ TO: _____

Diagnosis/Nature of Disability

Please include a clear diagnostic statement. If the criteria for a diagnostic disability is not present, this should be stated in the report. If multiple diagnoses or co-existing conditions are present which may affect academic progress, these should be included. Vision should include visual acuity. Hearing should include severity and a copy of the most recent audiogram.

_____

_____

DSM-IV Diagnoses (if applicable):

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Is this student a regular patient of yours? Yes ☐ No ☐

If yes, how frequently have you met with this patient in the past 2 years? _____

Last date of clinical assessment: _____

Date(s) of Diagnosis/Onset: _____

What, if any, relevant examinations, investigations or consultations have been completed?
(e.g. x-ray, clinical interview, MRI):

_____

_____

Is the disability:

☐ Permanent

☐ Chronic (present for past 2 years and expected to persist)

☐ Temporary (anticipated recovery date): _____

Is the nature of the illness:

☐ Fluctuating in function

☐ Cyclical

☐ Progressive

Impact on activities of daily living

☐ Please identify functional restrictions and limitations (see attached Form 1)

☐ Not applicable

Impact on educational and academic functioning

☐ Please identify functional restrictions and limitations:

_____

_____

☐ Not applicable

Medications

Is this student currently taking medication(s) for symptoms or receiving other treatment? Yes ☐ No ☐

If yes, what type of treatment: _____

If yes, what type of medication? Please identify below:

Brand or Generic Name	*Dosage and Frequency*	*Adverse effects currently experiencing that may impact academic functioning*

If yes, do limitations and symptoms persist even with medication? Yes ☐ No ☐

If yes, please describe residual limitations:

_____

_____

Date of next assessment: _____

Recommended Treatment and Intervention plan (i.e. physiotherapy, referrals):

_____

_____

Please add any additional information that you believe is important to assist us in determining the appropriate services at the university.

_____

_____

Thank you for taking the time to complete this portion.

Practitioner Information

Name of Health Practitioner (Please Print):_____

Please indicate the type of health care you practice:

Audiologist	☐	Physician (Family)	☐	Occupational Therapist	☐
Optometrist	☐	Ophthalmologist	☐	Speech-Language Pathologist	☐

Other: _____

Facility name and address (please use official stamp):

Practitioner's Signature: _____

Date: _____

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Form 1: Impact on daily living

Please complete this form fully to explain degree of impact.

Degree of Impact

Reduced ability to walk long distances	Mild ☐	Moderate ☐	Severe ☐	NA ☐
Unable to sit for long periods (Recommended length of time) _____)	Mild ☐	Moderate ☐	Severe ☐	NA ☐
Unable to stand for long periods (Recommended length of time) _____)	Mild ☐	Moderate ☐	Severe ☐	NA ☐
Gross motor function affected	Mild ☐	Moderate ☐	Severe ☐	NA ☐
Fine motor function affected	Mild ☐	Moderate ☐	Severe ☐	NA ☐
Frequent need for washroom	Mild ☐	Moderate ☐	Severe ☐	NA ☐
Fatigue	Mild ☐	Moderate ☐	Severe ☐	NA ☐
Frequency of persistent pain	Mild ☐	Moderate ☐	Severe ☐	NA ☐
Lethargy	Mild ☐	Moderate ☐	Severe ☐	NA ☐
Diminished concentration	Mild ☐	Moderate ☐	Severe ☐	NA ☐
Dizziness	Mild ☐	Moderate ☐	Severe ☐	NA ☐
Drowsiness	Mild ☐	Moderate ☐	Severe ☐	NA ☐
Decreased ability to function affected at particular time periods: **in the A.M.**	Mild ☐	Moderate ☐	Severe ☐	NA ☐
in the P.M.	Mild ☐	Moderate ☐	Severe ☐	NA ☐
Social functioning - inability to participate in group situations	Mild ☐	Moderate ☐	Severe ☐	NA ☐
Social functioning - inability to participate in presentation activities	Mild ☐	Moderate ☐	Severe ☐	NA ☐
Speech affected	Mild ☐	Moderate ☐	Severe ☐	NA ☐
Other _____	Mild ☐	Moderate ☐	Severe ☐	NA ☐

Physician's Signature: _____

Date: _____