# Documentation of Sensory, Physical and Medical Disabilities

**Services for Students with Disabilities**
**Student Development Centre**

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## *Purpose of this form*

Services for Students with Disabilities (SSD) requires documentation from a licensed health care professional, who is qualified to communicate a diagnosis and has in-depth knowledge of a student's condition, in order to arrange academic accommodation and/or related services. Information on this form also may be used to assess a student's eligibility for financial support. Documentation should be as complete as possible in order to facilitate SSD's assessment of a student's request for services.

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## *To be completed by student*

**Student Name:** ______________________________ **Date of Birth:** _____/_____/_____

(Year/Month/Day)

**Student Number:** ______________________________

I authorize the professional named below to disclose to Services for Students with Disabilities (SSD) information on this form and additional or clarifying information that is necessary for provision of disability services at Western University. I also authorize SSD to communicate with this professional in order to obtain information that is relevant to provision of SSD's services.

Date : ____________ ________________ Student Signature : ______________________________

Student's informed authorization for disclosure of information is obtained in accordance with the following sections of the *Freedom of Information and Protection of Privacy Act*. Sections 41.(1)(a), 41.(1)(b), and 41.(1)(c) allowing for the *use* of personal information and sections 42.(1)(b), s.42(1)(c), and s.42(1)(d) allowing for the *disclosure* of personal information.

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## *To be completed by licensed health care professional*

Name (please print): ______________________________

Registration Number: ______________________________

Address of medical professional:

______________________________

______________________________

Telephone #: ______________________________

Fax #: ______________________________

Profession:
☐ Family Physician ☐ Pediatrician ☐ Other__________________

Signature: ______________________________

Date: ______________________________

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## *Diagnostic Statement*

Please provide a clear diagnostic statement or indicate that the student's difficulties do not meet criteria for a diagnosis. If more than one condition is present that may affect academic progress, please specify all relevant conditions.

***Diagnosis***

______________________________________________________________________________

______________________________________________________________________________

Date of the condition's onset: ____________________________________________________________

Date of last clinical assessment: __________________________________________________________

How long have you been treating this student? _____________________________________________

## *Statement of Permanent Disability*

The designation of permanent disability has legal implications and is used in determining a student's eligibility for government grants and loans. Please refer to the following definition of permanent disability when answering the question below it.

Permanent disability is defined as a **functional limitation** due to a disorder that restricts a 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.

In your professional opinion, does the student's condition meet criteria for a permanent disability as defined above? Yes □ No □

## *Please check the appropriate description(s) as they apply to this student's condition.* (Check all that apply)

☐ Not a disabling condition in the current academic setting

☐ Temporary disability: anticipated duration from ______________________ to _____________________

☐ Permanent disability with ongoing chronic symptoms

☐ Permanent disability with episodic symptoms. Is the student currently experiencing symptoms? _____

☐ Updated documentation regarding disability status should be reassessed every ___________________ because of the changing nature of the illness

| Abilities & Activities | No Impact | Mild Impact | Moderate Impact | Severe Impact | Don't Know |
|---|---|---|---|---|---|
| **To what degree does the disability directly affect the following physical and sensory capacities?** | | | | | |
| Hearing | | | | | |
| Speech | | | | | |
| Vision | | | | | |
| Mobility | | | | | |
| Dexterity | | | | | |
| **To what degree does the disability directly affect the following cognitive abilities?** | | | | | |
| Working memory | | | | | |
| Long-term memory | | | | | |
| Speed of information processing | | | | | |
| Language use | | | | | |
| Rational thinking and reasoning | | | | | |
| **To what degree is the disability associated with any of the following symptoms?** | | | | | |
| Pain | | | | | |
| Fatigue | | | | | |
| Poor Concentration | | | | | |
| **To what degree does the disability create functional limitations specific to the following academic tasks when adaptations have *not* been made or assistive devices are *not* used?** | | | | | |
| Handwriting | | | | | |
| Typing or keyboarding | | | | | |
| Listening | | | | | |
| Reading | | | | | |
| Speaking | | | | | |
| | | | | | |

**Does the disability affect the student's tolerance for:**

☐ sitting for less than 50 minutes

☐ sitting for more than 50 minutes

☐ standing for more than 15 minutes

☐ walking (cannot walk more than ____ meters at a time)

☐ lifting (cannot lift more than _______kg)

☐ reaching above shoulder level

☐ twisting: neck, back, knees, wrists (please circle all that apply)

☐ bending: neck, back, knees, wrists (please circle all that apply)

☐ performing activities of daily living (please list):

If possible, please estimate how often the effects of the student's disability may necessitate his or her absence from classes: ☐ < 1 day per month ☐ 2-5 days per month ☐ >5 days per month

Is it your opinion that the student will be able to meet the demands of a full course load (15-25 hours of lectures, labs, and/ or tutorial meetings per week plus 25-30 hours of study time per week? ☐ yes ☐ no

If you answer is no, please estimate the maximum amount of time that the student would be able to spend in these activities: approximately ________________ hours per week.

Will you be monitoring this student on a regular basis while he or she is attending university?

☐ yes ☐ no

Are there situations or activities that may worsen this student's condition?

### *Medication Information*

Please list medications that the student is taking.

| *Brand or Generic Name* | *Dosage and Frequency* | *Adverse effects **currently experienced** that may affect academic functioning* |
|---|---|---|
| | | |
| | | |
| | | |

### Additional Information:

***Thank you for taking the time to complete this form.***